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ABSTRACT

This guide to mainstreaming health impaired preschoolers is one of a series of eight manuals on mainstreaming preschoolers developed by Project Head Start. The guide is addressed to parents, teachers and other professionals and paraprofessionals. Chapter I presents information on the meaning, benefits and implementation of mainstreaming. The role of the teacher in mainstreaming is discussed, and sources of assistance are listed. Chapter II distinguishes between handicapping and nonhandicapping health impairments, and defines health impairments as illnesses of a chronic nature or with prolonged convalescence. The following conditions and diseases that result in health impairments are briefly delineated: epilepsy or convulsive disorders, syndromes, pituitary problems, hypothyroidism and diabetes, inborn errors of metabolism, tuberculosis, cystic fibrosis, asthma, congenital heart defects, anemia, hemophilia, and nephrosis, nephritis and enuresis. Chapter III describes how health impairments affect learning in 3- to 5-year olds, and enumerates measures to take in emergency situations. Chapter IV focuses on planning, arranging classrooms, and teaching mainstreamed health impaired children. Chapter V describes how parents and teachers can work together while Chapters VI and VII provide information on possible resources and sources of help, professional and otherwise. Notes on screening and diagnosis are appended. (CM)

Project Head Start

U.S. DEPARTMENT OF HEALTH,
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Children with Health Impairments

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Head Start Bureau

Special Message to Parents

This book is meant to help parents as well as teachers understand mainstreaming and health impairments. Chapter 5 describes specific ways in which parents can help their health impaired child. But parents will find the other chapters useful in learning more about development in health impaired youngsters, techniques and activities to promote learning, how Head Start functions in serving handicapped children, and what resources outside of Head Start are available to help fill their child's special needs.

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Mainstreaming Preschoolers:

Children with Health Impairments

A Guide for Teachers, Parents, and Others Who Work with Health Impaired Preschoolers

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The authors were fortunate in being able to draw on the advice and contributions of many knowledgeable and talented people during the preparation of this book. Chief among them were the following experts on health impairments and early childhood education, who reviewed the text in its successive versions and gave us many excellent suggestions for improving it:

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Preface

Project Head Start was initially conceived and launched as a national program of comprehensive developmental services for preschool children from low-income families. The early design also indicated that the comprehensive program should be tailored to the needs of the individual community and of the individual child.

The Head Start Program Performance Standards require local programs to develop an educational plan that provides procedures for ongoing observation, recording, and evaluation of each child's growth and development for the purpose of planning activities to suit individual needs. The Performance Standards also require that classroom materials and activities reflect the cultural background of the children. Thus, individualization has always been a major thrust of the Head Start program.

The Congressional mandate to assure that not less than 10 percent of enrollment opportunities in Head Start be available for handicapped children presented special opportunities and challenges to Head Start programs to further their efforts in the individualization of services. Head Start classes are small, making it possible for teachers, working with a professional diagnostic team, to design a program to meet the special needs and capabilities of each child.

Mainstreaming handicapped children into classrooms with non-handicaped children has become a major activity for Head Start. However, teachers and other staff are continually asking for assistance in mainstreaming a child with a specific handicapping condition. This series of eight manuals, **Mainstreaming Preschoolers,** was prepared by ACYF to help meet this need.

The series was developed through extensive collaboration with many persons and organizations. Under contract with Contract Research Corporation, teams of national experts and Head Start teachers came together to develop each of the manuals. At the same time, the major national professional and voluntary associations concerned with handicapped children were asked to critique the materials during their various stages of development. Their response was enthusiastic. Various federal agencies concerned with handicapped persons — the Bureau of Education for the Handicapped, the President's Committee on Mental Retardation, the Office of Developmental Disabilities, the National Institute of Mental Health, the Office of Handicapped Individuals, National Institute of Child Health and Human Development/National Institute of Health, and Medicaid/Early and Periodic Screening, Diagnosis, and Treatment — also enthusiastically reviewed the materials as they were being developed. Finally, drafts of each of the manuals were reviewed by teachers, paraprofessionals, parents, social service and health personnel, and various other specialists in Head Start programs across the country.

It is hoped that this series will be helpful to the variety of people beyond the Head Start community — in public schools, day care centers, nursery schools, and other child care programs — who are involved in providing educational opportunities and learning experiences to handicapped children during the preschool years.

Blandina Cardenas, Ed.D.

Commissioner
Administration for
Children, Youth and Families

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Introduction

The Purpose of This Book

This book was written for teachers, parents, and others, such as diagnosticians and therapists, who work directly with health impaired preschoolers. It provides some good ideas for helping health impaired children learn and feel good about themselves, and answers many questions, including:

What is mainstreaming?

What are health impairments?

How do health impairments affect learning in three- to five-year-olds?

How can you design an individualized program for a health impaired child?

What activities are especially useful for children with health impairments?

How can parents help their health impaired child?

Where can you go to seek help—people, places, and information?

The information in this book is also useful for working with all preschool children, non-handicapped as well as handicapped.

The Organization of This Book

This is one of a series of eight books on children with handicaps, written for Head Start, day care, nursery school, and other preschool staff, and parents of children with special needs. Each book is concerned with one handicapping condition. The other seven books address:

- **emotional disturbance**
- **hearing impairment**
- **learning disabilities**
- **mental retardation**
- **physical (orthopedic) handicaps**
- **speech and language impairments (communication disorders)**
- **visual handicaps.**

There are certain guidelines that are similar in working with all kinds of handicapped preschoolers. These guidelines should be useful to teachers and parents who are directly involved with children with special needs. They are described in the chapters "What Is Mainstreaming?" "Parents and Teachers as Partners," "Where to Find Help in Your Area," and the sections on planning, the physical setting, and general teaching guidelines in the chapter "Mainstreaming Children with Health Impairments." While these chapters (or sections of chapters) are largely the same in most of the books in this series, the examples and suggestions provided in each book are specific, and will help you apply the general information to a child with a particular handicap.

A Word on Words

In this book the terms **handicapped children** and **children with special needs** mean the same thing.

Chapter 1:

What Is Mainstreaming?

Mainstreaming is learning and working together.

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What Does Mainstreaming Mean?

"Mainstreaming" means helping people with handicaps live, learn, and work in typical settings where they will have the greatest opportunity to become as independent as possible. In Head Start programs, mainstreaming is defined as the integration of handicapped children and non-handicapped children in the same classroom. It gives handicapped children the chance to join in the "mainstream of life" by including them in a regular preschool experience, and gives non-handicapped children the opportunity to learn and grow by experiencing the strengths and weaknesses of their handicapped friends.

However, mainstreaming does not simply involve enrolling handicapped children in a program with non-handicapped children. Definite steps must be taken to ensure that handicapped children participate actively and fully in classroom activities. As a Head Start teacher, it is your role to take these steps.

Mainstreaming is not new to Head Start. Since its beginning, Head Start programs have included handicapped children in classrooms with non-handicapped children. The Economic Opportunity Amendments of 1972 (Public Law 92-424) required that ten percent of the Head Start enrollment in the nation be handicapped children. Two years later, the Headstart, Economic Opportunity, and Community Partnership Act of 1974 required that, by fiscal year 1976, not less than ten percent of the total number of enrollment opportunities in Head Start programs in each state be available to handicapped children. And most recently, Public Law 94-142, the Education for All Handicapped Children Act, has mandated that the public schools provide "free, appropriate education" in the "least restrictive setting" for handicapped children from 3 to 21 years of age. Thus, mainstreaming has become an important and well-accepted approach in the education of young handicapped children.

It is the function of Head Start programs to:

> **serve handicapped children in an integrated setting or mainstream environment with other children; provide for the special needs of the handicapped child; and work closely with other agencies and organizations serving handicapped children in order to identify handicapped children, and provide the full range of services necessary to meet the child's developmental needs.**

(Head Start Transmittal Notice 75.11—9/11/75.)

Research on children has shown over and over that the early years of life are critical for learning and growth. It is during this time that children's cognitive, language and speech, social, and emotional development can be most influenced. If special needs are recognized and met during these years, handicapped children will have a much better chance of becoming competent and independent adults. Handicapped youngsters who are given the opportunity to play with other children in the Head Start classroom learn more about themselves and how to cope with the give and take of everyday life. This is one of the first steps toward developing independence. By participating in regular preschool settings that are able to provide for special needs, with teachers who know how to adapt teaching techniques and activities, children with special needs will truly have a "head start" in achieving their fullest potential.

Benefits of Mainstreaming

There are many benefits to mainstreaming—benefits that affect both handicapped and non-handicapped children, as well as their parents and teachers.

Mainstreaming Helps Handicapped Children

Participating in a mainstream classroom as a welcome member of the class teaches children with special needs self-reliance and helps them master new skills. For some, it may be the first time in their lives that they are expected to do for themselves the things they are capable of doing. Working and playing with other children encourage handicapped children to strive for greater achievements. Working toward greater achievements helps them develop a healthy and positive self-concept.

Mainstreaming can be an especially valuable method for discovering undiagnosed handicaps. Some handicaps don't become evident until after a child enters elementary school, and by then much important learning time has been lost. A preschool teacher is able to observe and compare many children of the same age, which makes it easier to spot problems that may signal a handicap. Preschool may therefore be the first chance some children get to receive the services they need.

Mainstreaming Helps Non-Handicapped Children

Mainstreaming can help non-handicapped children, too. They can learn to accept and be comfortable with individual differences among people. Some studies have shown that children's attitudes toward handicapped children become more positive when they have the opportunity to play together regularly. They learn that handicapped children, just like themselves, can do some things better than others. In a mainstream classroom, they have the opportunity to make friends with many different individuals.

Mainstreaming Helps Parents

Mainstreaming is also good for the parents of children with special needs. With you, the other members of the staff, and specialists sharing the responsibility for teaching a child, the parents come to feel less isolated. They can learn new ways to help their own child. As they watch their child progress and play with non-handicapped children, parents are helped to think about the child more realistically. They will see that some of the behavior they are concerned about is probably typical of all young children, not just children with handicaps. In these ways, parents come to feel better about their children and themselves.

Mainstreaming Helps Teachers

Mainstreaming also has advantages for you. You have the chance to make a significant impact on a handicapped child. The techniques you develop for working with a child with special needs are just as useful with non-handicapped children who have minor weaknesses in the same areas. In fact, many of the most effective teaching techniques known were first developed for handicapped children. Finally, working with handicapped children is a chance to broaden both your teaching and personal experience.

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How Is Mainstreaming Carried Out?

Mainstreaming can be carried out in a variety of ways. How you decide to mainstream a particular handicapped child will depend upon the child's strengths, weaknesses, and needs, and will also depend upon the parents, the staff and resources within your program, and the resources within your community. As you know, every child is an individual with different needs and abilities. This is just as true for handicapped children: they display a broad range of behavior and abilities.

Some handicapped children may thrive in a full-day program with non-handicapped children. Others will do best in a mainstream environment for only part of the time, attending special classes or staying at home for the rest of the day. For still others, mainstreaming may not be the most helpful approach. The principle to follow is that handicapped children should be placed in the "least restrictive environment." This means that the preschool experiences of handicapped children should be as close as possible to those of non-handicapped children, while still meeting the special needs created by their handicaps.

Mainstreaming involves the efforts of many people working as a team—teachers, the child's parents, Head Start staff (in health, education, handicap, parent involvement, and social services), other specialists providing consultant services on a full- or part-time basis, agencies serving handicapped children, and the public schools in the community. The identification, development, and coordination of this team effort is both a challenge and a critical requirement in meeting the needs of a handicapped child.

As you and your program staff get to know each child, and as you work with the child's parents and specialists in your community's agencies and public schools, you will be able to decide what is best for each child. This book describes *how* mainstreaming can be carried out by the parent/Head Start/specialist team in order to provide the best program for both handicapped and non-handicapped children.

This book also discusses different kinds of health impairments and describes some of the things children with various impairments can do as well as other children and things they may have some trouble doing. Also included are general teaching guidelines and ways to modify specific activities for use with health impaired children.

2

What is Your Role in Mainstreaming?

This book approaches mainstreaming from the standpoint of child development. It emphasizes the importance of seeing handicapped children first and foremost as children, with the same needs all children have for love, acceptance, exploration, and a sense of competence. By understanding how all children develop and learn you can better understand the effects of a particular handicapping condition. For example, knowing the importance of normal growth and development will help you understand the special needs of a health impaired child. You can then use this knowledge to plan appropriate activities for building on the child's strengths and working on his or her weaknesses.

The teaching techniques and activities provided in this book are designed to help develop skills in particular areas of development—motor, social, intellectual, language and speech, and self-help—and can be used with any child or group of children in your classroom, whether they are handicapped or non-handicapped.

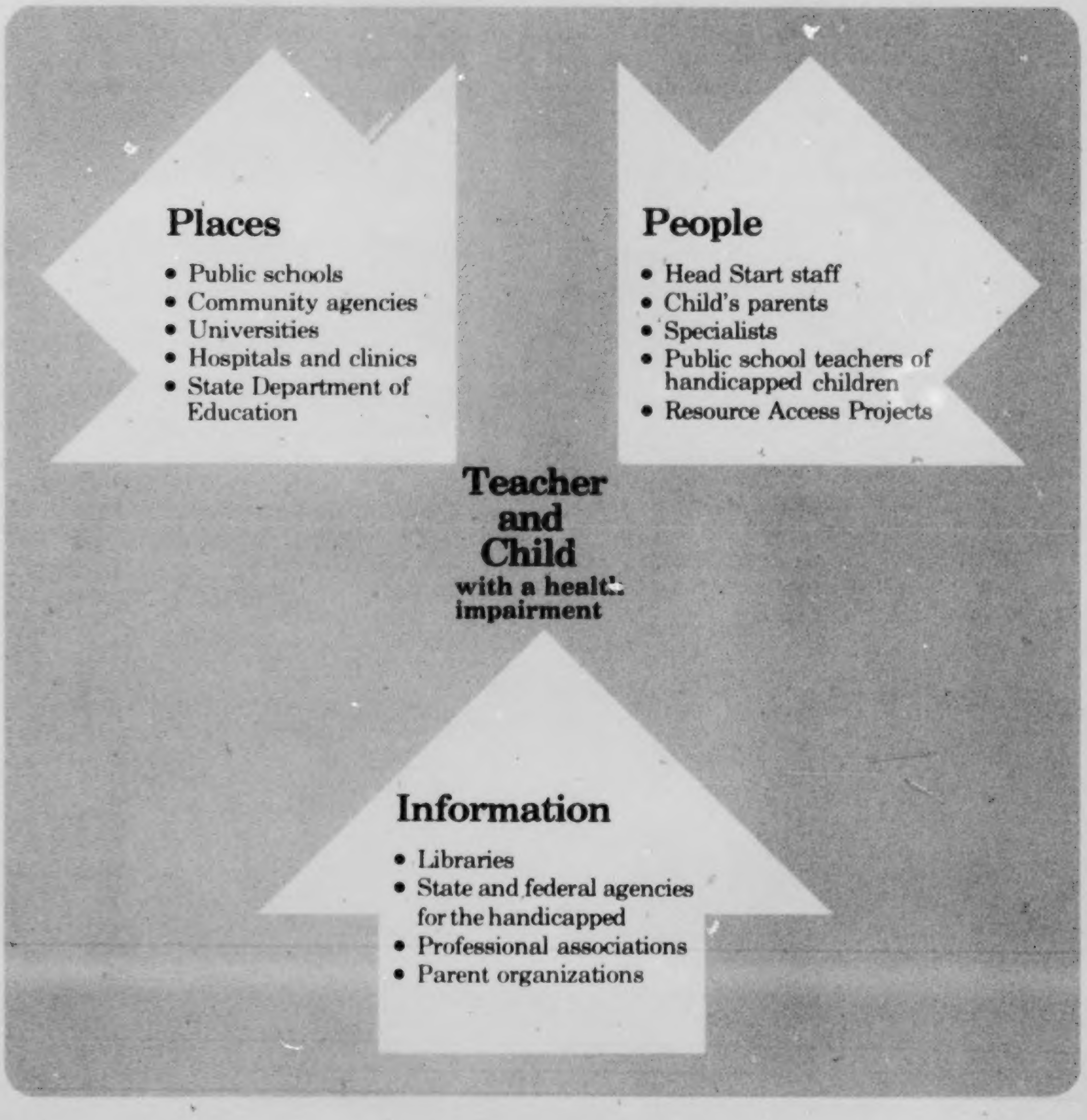
As a teacher, your role in mainstreaming includes:

- **developing and putting into effect an individualized program that meets the needs of each child in the classroom, including the special needs of a child with a handicapping condition**
- **working together with the parents of a handicapped child so that learning situations that occur in your classroom are reinforced by the parents at home**
- **finding out, through your handicap coordinator or social services coordinator, what special services a handicapped child is receiving and how you can get a specialist to help you in your classroom teaching**
- **arranging referrals through your handicap coordinator or social services coordinator for diagnostic evaluations, if you feel a child has a problem that has not been clearly identified.**

In carrying out this role, there are many resources that can be tapped to assist you. Later in the manual they will be described in more detail, but they are summarized on the following chart.

8 Where to Go for Help

There are many resources you can tap for help with a handicapped child. Take advantage of these resources by actively seeking them out. For detailed information on Head Start and other resources in your area, see Chapter 6. For detailed information on national professional and parent associations and agencies, and a list of helpful materials, see Chapter 7.



Places

- Public schools
- Community agencies
- Universities
- Hospitals and clinics
- State Department of Education

People

- Head Start staff
- Child's parents
- Specialists
- Public school teachers of handicapped children
- Resource Access Projects

Teacher and Child
with a health impairment

Information

- Libraries
- State and federal agencies for the handicapped
- Professional associations
- Parent organizations

Chapter 2:

What Are Health Impairments?

2

Health problems are not necessarily health impairments.

When Is a Health Problem a Handicap?

This chapter describes those handicapping conditions called health impairments. Health impairments include most of the conditions that are usually considered illnesses, such as diabetes, asthma, and anemia. Many children and adults with these problems are not handicapped by them. Others are *handicapped, when their health problem seriously interferes with their growth or development. Let's look at some examples.*

At birth, Nancy appeared to be a beautiful and healthy baby. Her parents were delighted that she soon smiled, held her head up, and by four months of age was beginning to roll over. They took her regularly to their doctor for immunizations and check-ups. At five months Nancy had what appeared to be a brief bout with pneumonia—she had difficulty breathing and had to be hospitalized. Two months after her recovery she suffered another attack, much like the first. By age three, she had been hospitalized five times. Each time she wasn't very sick, but she did have difficulty breathing. Her doctor and parents were not aware that Nancy was having asthma attacks, which occurred when the tubes leading to her lungs narrowed and caused her to wheeze. Nancy was a curious child who enjoyed learning new skills. However, as a preschooler she had attacks almost every day, making her miss many of the preschool's activities. Because she was absent so often, she was always "catching up" with the rest of her playmates, rather than learning along with them.

Nancy didn't wear braces or use crutches. She could see and hear well and was bright. Even so, she was a child with a **handicap**. Her asthma was a health impairment, because it was interfering with her growth and development. She was not able to play as long or as hard as her playmates and she missed almost every other day of preschool. In addition, her special problems called for changes in her activities. Even though she tried very hard, and her parents worked very closely with her teacher, Nancy just couldn't keep up.

Wing, another child in Nancy's group, also had asthma, in a milder form. He took the same medicine as Nancy, but he didn't miss class, and he never had to be in the hospital. Wing had a health problem, but it didn't interfere with his growth or development, and it didn't require special services. So he wasn't considered to be a child with a handicap.

How Are Health Impairments Defined?

In defining handicapping conditions, Project Head Start distinguishes between **categorical** definitions, which are used for reporting purposes, and **functional** definitions, which describe a child's areas of strength and weakness. The categorical definition uses Project Head Start's legislated diagnostic criteria. An interdisciplinary diagnostic team (or a professional who is qualified to diagnose the specific handicap) must use this definition to make a categorical diagnosis of a child. This diagnosis is used only for reporting purposes. A functional definition or diagnosis, on the other hand, assesses what a child can and cannot do, and identifies areas that call for special education and related services. The functional assessment should be developed by a diagnostic team, with the child's parents and teacher as active participants. Another term for functional assessment or functional diagnosis is **developmental profile.**

According to Project Head Start, the following categorical definition of health impairments is to be used for **reporting purposes** in Head Start programs:

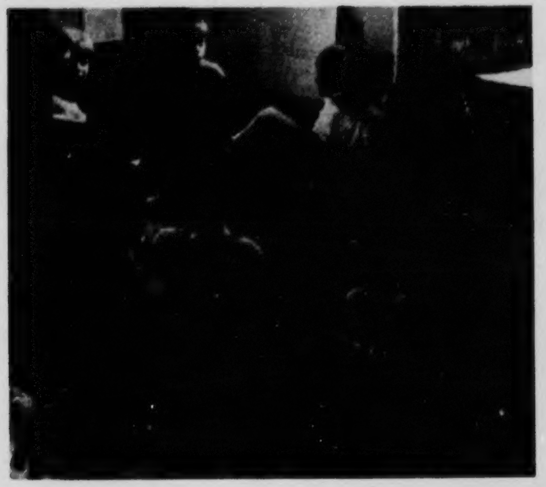
> **These impairments refer to *illnesses of a chronic nature or with prolonged convalescence,* including, but not limited to, epilepsy, hemophilia, severe asthma, severe cardiac conditions, severe anemia or malnutrition, diabetes, or neurological disorders.**
>
> ("Transmittal Notice Announcement of Diagnostic Criteria for Reporting Handicapped Children in Head Start," OCD-HS, September 11, 1975.)

The key words in this definition are **chronic** and **prolonged convalescence.** They refer to health problems that severely affect learning.

Many impairments are not considered handicaps by Project Head Start if the conditions do not require special services. For example, a child whose vision can be corrected with eyeglasses is not considered visually handicapped. Children are considered handicapped if they fall within the legislative definition and if, by reason of this handicap, they **require special education and related services.**

How Do Health Impairments Affect Learning?

The term **handicap** is usually used when a child has a health problem that affects learning: that is, taking in information, thinking about that information, and acting on that information (e.g., moving about or communicating). Almost all handicaps other than health impairments directly interfere with the child's ability to gain information (blindness, deafness) or to use information to communicate (mental retardation). Many also directly interfere with communication itself (speech impairments). Health impairments interfere with the child's opportunity to participate fully in learning activities by affecting the body's supply of energy or the removal of wastes, or by creating severe problems with growth.



Growth and Development

The terms **growing** and **developing** are often used to mean the same thing, as in "Suzie is growing well," and "Larry is developing nicely." However, growing and developing mean separate things—and each child participates in both while becoming an adult. Growth means an increase in size: becoming taller and heavier. Development means an increase in learning and understanding. Some children grow to the size of adults but never develop an adult's ability to understand. Other children do not gain weight or grow tall, but they develop normal adult intelligence. Ideally, children both grow and develop, given the proper food and varied and stimulating activities.

Growth

Children's size and rate of growth are characteristics that are determined, in part, by the genes they inherit. Johnny may be growing slowly, like his mother did when she was his age. Mary may be very thin and tall, just as her grandfather was. A small child is not necessarily an unhealthy child.

There are other factors that affect children's size and rate of growth: energy (food and oxygen) and hormones (chemicals produced by the body). We take in energy in order to grow, and we produce hormones to regulate our growth at a regular and "normal" pace. If Mary does not receive enough energy, or if her body is not able to use the energy properly (especially during the first two or three years of life), she may not grow as tall as her genes would have allowed. And if Johnny's hormones are out of balance, he may grow very quickly, instead of slowly.

A doctor can determine whether a child's height and weight appear normal by comparing them to the height and weight of other children of the same age. Doctors do this by using growth charts, which give the average height and weight for each age. This "average" is obtained by weighing and measuring thousands of children of a certain age. For example, if the weights of 100 four-year-old boys were written down in a long column of 100 numbers, you would quickly see that most of the weights were fairly close and it would be easy to arrive at an average weight. However, you would probably also find a few heavy boys and a few light boys on the list. Are the heaviest boy and the lightest boy unhealthy? They may be, but not necessarily.

This could be considered a **screening test** for growth. If the weight of a four-year-old boy is heavier or lighter than the normal range, the child needs to have a medical evaluation to determine if there is anything truly wrong with his growth. Doctors are also interested in the pattern of growth. If a child weighed about 70th in a group of 100 children in October, and in May weighed about 30th in the same group, the uneven growth pattern would alert the doctor that there might be a problem. Just because some children are especially small or large does *not* mean they are unhealthy—only that they must be reviewed more carefully to see if anything is wrong.

When there is a great difference between a child's weight and height, closer evaluation may be needed to determine if this difference represents a health problem.

2

Development

Development can be thought of as a process that enables children to know and do things they didn't know and couldn't do before. For this to happen, children take in information from their environment—or, more exactly, from people, things, and events in their environment. Next, children organize this information in their minds, which makes it usable. Last, they behave in a way that indicates that learning has taken place.

For example, Billy and Mary were playing on a teeter-totter at the playground. They weighed about the same and went up and down easily. When Billy saw his mother coming he quickly jumped off the teeter-totter, while Mary was still up in the air. Of course Mary came down quickly and hit the ground hard. This was the first time either had had this happen. Mary felt the sudden drop and bump, and yelled at Billy, "Don't do that again!" Billy also saw what happened and realized he had caused the problem by suddenly getting off. Mary and Billy now know what happens when you get off a teeter-totter with one person still in the air. That's development—and each day is full of such experiences for every child who is active and healthy.

14 Energy

To grow and develop properly, the muscles and organs of the body are dependent on energy being delivered promptly and on wastes being removed quickly. Any condition that interferes with the body's ability to take in and use energy, or with its ability to remove wastes, can result in a health impairment. This section looks at energy—what it is and how the body uses it.

The body requires two major kinds of energy: calories (units of heat) from the food we eat, and oxygen from the air we breathe. The calories and oxygen are the fuels that combine with other chemicals of the body so that the "work" of the body can be accomplished.

Food passes through the stomach to the intestines, where the calories are removed and carried in the blood through the blood vessels to be stored, or to the different areas of the body that need them. The lungs remove oxygen from the air, and the blood carries it through the blood vessels to areas of the body where it is combined with calories. The heart pumps the blood (and therefore the energy) to the muscles and other organs where energy is needed.

Every part of the body uses energy. Energy is needed when we think, speak, walk, see, hear, breathe, digest food, and even when we sleep. Certain activities take more energy than others. For example, it takes more energy to stand than it does to sit, or to run than it does to walk.

After the energy is used, the byproducts (wastes) remaining must be removed from the body. For all of us, there are three main kinds of wastes to be removed:

- **a gas, carbon dioxide, which is removed by the lungs when you exhale**
- **chemicals and acids, which are removed from the blood as it passes through the kidneys, and which leave the body in the urine**
- **remains of the food eaten, which pass through the intestinal tract and leave the body through the rectum. The liver is also indirectly involved, because it is the organ that prepares many of the chemicals so that the lungs and kidneys may remove them from the blood.**

2

Kinds of Health Impairments

There are many conditions and diseases that can result in health impairments. This section briefly describes the more common of these conditions. The bibliography suggests where to find more detailed information. In addition, the glossary at the end of this book explains some of the technical terms used by doctors and other health professionals.

Epilepsy or Convulsive Disorders

Epilepsy or convulsive disorders are conditions that can interfere significantly with energy use. In these disorders there is a sudden temporary excess of energy in the brain, which interrupts ("short-circuits") normal activity and results in a **seizure.** This interruption may be as simple as a staring spell only a few seconds long, as in **petit mal** seizures, or as dramatic as a few minutes of jerking movement, as in **grand mal** seizures. Other types of seizures are listed in the glossary at the end of this book.

In all types of seizures, the child's normal activity is briefly interrupted, and some type of reaction takes place. Following a seizure, some children sleep for a few minutes to a few hours. This sleep, which is normal, also keeps the child from participating in normal activity.

The causes of epilepsy are not completely understood. While in some people epilepsy seems to be inherited, in others epilepsy is caused by any type of damage to the brain, including high fevers and blows to the head. Many children have epilepsy with no known cause. Epilepsy may be caused before birth, at the time of birth, or at any time in one's lifetime. Medication (anti-convulsant drugs) can often be very effective in controlling and even eliminating seizures.

Syndromes

A syndrome is a disease, psychological disorder, or other abnormal condition that is indicated by a group of signs and symptoms that occur together repeatedly in a number of cases. Some syndromes impair growth and/or development. Many of the syndromes of childhood, such as **Down's syndrome** (Mongolism), directly interfere with understanding because the brain tissue itself is not constructed properly, or can't use or "process" the information. Other syndromes affect growth by causing physical defects that may be handicapping. For example, **Holt-Oram syndrome** causes defects in the upper limbs, shoulders, and heart.

Pituitary Problems, Hypothyroidism, and Diabetes

A very complicated system of hormones controls both growth and the use of calories and oxygen in producing energy. The three most important hormones are **growth hormone, thyroid hormone,** and **insulin.**

Growth hormone is made by the pituitary gland in the brain. The treatment of a child with pituitary problems is very complicated, and will need to be explained by a doctor if you have a child with this condition.

Thyroid hormone is extremely necessary for growth of the child's brain during the first few months and years of life. Thyroid hormone is like the thermostat in your heating system: too much, and all the energy is burned up too quickly; too little, and the child is very sluggish and slow moving. When there is not enough of this hormone the child is said to be hypothyroid. Children with too little thyroid have to take thyroid pills daily.

Insulin hormone allows oxygen to combine with carbohydrate calories to produce energy. If insulin is lacking, the body must use more fat calories, which overloads the body's waste-removal system. This condition is called **diabetes mellitus.** Children with diabetes need shots of insulin every day. Most diabetics can lead a normal life, though special attention has to be given to the kinds and amounts of food they eat.

Inborn Errors of Metabolism

Inborn errors of metabolism are a set of conditions that interfere with different body functions such as digestion. Digestive problems are caused, for example, when one of the chemicals necessary to help produce digestive juices is missing. Although the missing enzyme normally makes only a "drop" of material each day, that amount is extremely important. Without it the necessary energy is not available for growth or activity.

Tuberculosis

Tuberculosis is an infectious bacterial disease that causes tubercles (lumps) to form in the lungs, which impair the lungs' functioning. Before new drugs were available, tuberculosis was a major cause of growth and development problems in children. With modern health care, tuberculosis is rarely considered a handicap, although it still can be a serious health problem for a child who is not given the drugs needed to control it.

Cystic Fibrosis

Cystic fibrosis is an inherited condition in which the mucous glands, including those in the lungs, secrete very sticky mucous, resulting in digestion and breathing problems. This mucous interferes with the proper digestion of food because it affects the production of digestive **enzymes.** Enzymes are chemicals that help break down food so it can be digested. In order to help control digestive problems, children must take in digestive enzymes with their food, usually in pill form.

The sticky mucous in the lungs also interferes with the lungs' ability to take oxygen from the air into the blood. It also interferes with the opposite process—removing carbon dioxide from the blood and putting it back into the air. To help remove mucous from the lungs, children may receive **postural drainage** (a routine of pounding on the chest in a particular way) and **aerosal therapy** (the inhaling of mist from a special machine). These routines are usually done at home under the supervision of parents.

There are other problems as well. The build-up of mucous in the lungs may result in frequent episodes of pneumonia. Another problem is that the body constantly loses too much salt. In order to compensate for this loss, children with cystic fibrosis must heavily salt their food, and often need to take salt tablets as well.

Asthma

Asthma is a condition caused by an allergy to some material (called an **allergen**). The allergen varies from child to child. In some instances, it is a material that is breathed in the air. In other instances, the allergen is unknown. The child with asthma has a rather sudden onset of difficulty moving air in and out of the lungs—especially out—because the major tubes leading to the lungs (called **bronchi**) become too narrow. The child then has difficulty both in bringing new oxygen into the body to burn and in eliminating the wastes, especially carbon dioxide.

Asthma, in many instances, can be controlled by medications taken orally or through special equipment (**nebulizers**) that make the medicine a fine mist that can be breathed in. Some children, however, despite excellent medical care and very cooperative parents, continue to have difficulty.

Asthma can continue into adulthood, sometimes taking a milder or a more severe form.

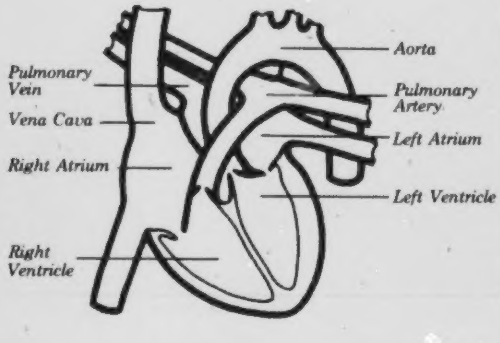
Congenital Heart Defects

Once energy sources (calories and oxygen) are absorbed into the blood, they must be transported throughout the body. The heart pumps the blood through a series of chambers and large vessels, and controls the flow of blood by valves located between the chambers. The blood vessels carry the blood to the muscles and other organs where the energy is needed.

Problems may occur because the vessels or the heart have congenital defects. ("Congenital" means that the child was born with the problem.) For example, the heart may have the vessels leading to or from it arranged in the wrong way, or they may be too small to carry enough blood. The chambers of the heart may be too big or too small, or there may be holes between the chambers that shouldn't be present.

Any of these conditions may be severe enough to limit the supply of energy to the child's body, which can then interfere with the child's ability to grow or to play with other children. Some of these problems can be corrected or improved by surgery.

The Heart



Anemia

The blood carries oxygen and calories to the vital organs that require energy. To carry the oxygen, the red blood cells combine with it. Problems occur if not enough or the wrong kind of red cells are present. This condition, called anemia, results in a child's feeling listless and weak.

Iron is necessary for the red blood cells to carry oxygen. If not enough iron-rich foods are eaten, iron deficiency anemia may result. The remedy is to change the diet to include iron-rich foods. Nutritionists or dieticians can provide this kind of information. (Very few children require iron medicine.) A change in eating habits, as outlined by a nutritionist or dietician, can benefit all the family members, not just the anemic child.

If the red blood cells are defective, they can't carry the correct amount of oxygen. This occurs in **sickle cell trait, thallessemia,** or **spherocytosis.** A child with any one of these conditions may also develop anemia.

Hemophilia

Hemophilia is an inherited condition that affects male children. Females can pass the condition on to their children, but it would be very rare for them to inherit the condition themselves. Children with hemophilia have difficulty controlling bleeding once their bodies are cut or bruised. So much blood may escape that the child's energy supply is severely limited. The most common problem, however, is bleeding into the joints (such as knees or elbows). Today, prompt medical attention usually prevents serious consequences. However, the child may have many short-term absences or hospitalizations in order to avoid serious blood loss and the resulting loss of energy.

Nephrosis, Nephritis, and Enuresis

The kidneys filter the blood to remove water and waste chemicals from it. **Nephrosis** and **nephritis** are diseases of the kidney that interfere with the filtering system so that wastes are not properly removed. In nephrosis, protein is lost through the kidneys. Nephritis sometimes follows "strep" throat infections, and results in high blood pressure. Both of these diseases are associated with excessive fluid in the tissues (called **edema**). These conditions can be treated with drugs and most children do recover.

The fluid produced by the kidneys—urine—is transported to the bladder through tubes (called **ureters**) and then from the bladder through a tube (called the **urethra**). The ureters and urethra may have congenital defects that make them too big, too small, or blocked. This results in **hydronephrosis,** in which urine is dammed up and flows back up to the kidneys, where it may damage them. Hydronephrosis causes a gradual build-up of internal poisons in the body. There are a number of ways that surgery may correct these kinds of problems.

Some children experience **enuresis**: wetting the bed at night (**nocturnal enuresis**) or their pants during the day (**diurnal enuresis**). Learning to control the bladder takes more time for some children than for others. Some may have control and never have an "accident" after two years of age. Other children may be wet every night until the age of four to six. The pattern varies among children for unknown reasons. There are many causes, including medical conditions, that can be remedied. All children with this problem should be checked by a physician.

2

Recognizing Problems for Referral

Usually health impaired children are diagnosed before their enrollment in a Head Start program. Occasionally, however, a child with an undiagnosed health impairment may be enrolled. Diagnostic evaluation is necessary to understand the needs of such a child, so that appropriate services may be provided. Sometimes a child may be diagnosed, but not receiving proper treatment. The Head Start teacher may be the first person in the life of a child who can observe and alert other appropriate professionals to the child's need for evaluation and/or treatment. Sometimes parents need advice and encouragement from teachers to recognize and face problems that may have troubled them in their child's behavior.

It is the responsibility of a professional diagnostician to determine whether a child is handicapped. Head Start staff should be alert to behavior that may signal health problems in children, talk to the parents, and refer those children to specialists.

General Guidelines

Learn to Observe Carefully

Your own classroom observation, plus conversations with parents about what they notice about their children, can be the best foundation for deciding whether to refer a particular child to a professional diagnostician.

As a classroom teacher, you observe children every day. In fact, observing may have become such a habit that you are unaware of it. Think back, for example, to the last week or month. What did your children enjoy? Dislike? Which activities did they do well in? Which did they have problems with?

These kinds of observations can help you plan activities to meet the individual needs of all the children. Even though you aren't a professional diagnostician, don't underestimate your ability to spot serious problem areas that may signal a youngster's handicapping condition. Observations of a diagnosed child can also be useful to a specialist who has been asked to consult with the staff—and therefore helpful to the child.

Ask Questions

Ask yourself some good, basic questions to determine whether a child should be referred for diagnostic evaluation. There are very few symptoms that *always* mean a child is in difficulty. For instance, many health impaired children tire easily, but all of the children in your program no doubt appear very tired from time to time. The child with petit mal seizures may appear to be daydreaming. The child with a psycho-motor seizure problem may make automatic movements such as buttoning and unbuttoning a sweater, or may repeatedly ask questions that were just answered. But any child in your program may demonstrate these kinds of behavior from time to time. Ask yourself:

Is this child's behavior unusual?

Does this behavior occur repeatedly?

If your answer to both of these questions is yes, and if the parents agree, referral is in order.

You observe children every day

Recognize Cultural Differences

It is important to distinguish between children who are different and children who may be handicapped. Since the children in your classroom come from a variety of backgrounds and child-rearing experiences, it is only logical that they will react to your classroom in a variety of ways.

For example, if a child often appears to be sick and misses many days of class, you may begin to suspect a health impairment. On close investigation, however, you may find that the reason for the child's absences is that the parents are overly concerned about sending the child to preschool with a runny nose or other minor ailment. Other unusual behavior in a child may be due to the fact that the parents require their child to "sit quietly and not speak," or to wash his or her hands every time he or she touches something. While a child's behavior may concern you, the child may simply be behaving as the parents have instructed (or as the child has seen *them* behave). It is your job to determine whether unusual behavior is normal for the child's background and child-rearing experiences.

Recognize Individual Differences

Distinguish between those children whose temperaments and individual learning styles you find difficult and those children who may be handicapped. Children, like adults, can be slow or fast to catch on to things, can be quiet and thoughtful or very energetic and into everything. Some get frustrated more easily than others, some get distressed and upset more easily than others, and some demand more attention than others. It is helpful to ask yourself: "Do I find this child difficult because of individual style differences between the two of us? Or is the behavior of the child greatly different from the range of behavior shown by other children the same age?"

Make Sure Children Receive Medical Attention

All children should receive regular medical attention. Children with health impairments, especially, should be evaluated at least every year and in most cases need medical attention every three to six months. Ask parents to tell you when their child is scheduled for medical evaluation. For many reasons, parents may sometimes fail to see that their child has check-ups. If parents are not following through on medical appointments and treatment routines, a referral should be made to the Head Start nurse or health coordinator.

You may have an instance in which both you and the parents are concerned about a child's health. Their daughter has been seen at a clinic several times, for example, but her health doesn't seem to improve. Some health impairments are very difficult to diagnose and treat. Most doctors will not have had contact with *every* kind of health impairment. You may want to ask the appropriate person in your health component to help the parents seek additional medical consultation.

Get Professional Help

From the child's point of view, referral is better than non-referral. This means that if you think a health impairment might account for the behavior you have observed, it is best to have the child professionally evaluated. If you find out that the child does not have an impairment, no harm has been done. If, on the other hand, a handicapped child is not diagnosed, the child's special needs will not be met.

Steps to Take

1. Find out whether the standard screening tests have been given. Talk to the handicap coordinator, the person responsible for coordination of health services, or someone else in your program who you think could be helpful.

2. If the child has been screened, no problems have been found, and you are still concerned about the child, speak to the handicap coordinator, health coordinator or social services coordinator. The parents will have to give their permission for further testing. Explain the professional diagnostic process and the reasons for it to the parents.

3. While waiting for a professional diagnosis:

- Talk with the parents about what they notice to help you work more efffectively with the child.
- Continue to observe and keep notes to help you plan suitable activities.
- Chapter 4 discusses guidelines and ways of conducting activities for children. Use them if they seem appropriate and if you find they work.

4. Find out the results of additional tests so that you can determine whether your individualized program for the child needs to be changed. Discuss with the parents the results of the tests and any suggested changes in the services the child is receiving.

Chapter 3:

How Health Impairments Affect Learning in 3- to 5-Year-Olds

3

You will want to know more than a diagnosis.

By the age of three, most children with health impairments have been evaluated by specialists. They should come to your class already diagnosed as having a specific health impairment. You will want to know more than the diagnosis, however. You will want to know how the child functions in various areas of development: using his or her body, thinking, communicating, his or her feelings about him- or herself, and how he or she gets along with others. Of course, these are things you want to know about all children. But with a health impaired child you need to know to what extent the impairment limits the child's functioning in any of these areas.

With some kinds of handicaps, such as speech or hearing impairments, it is possible to discuss problems in particular areas of development. This is difficult with health impairments because there is such a variety of health impairments, and because the severity of any one condition can vary from very mild to very severe. This chapter discusses levels of impairment and what they mean to you as a teacher. It also describes how to handle medication and emergency situations.

What Children with Health Impairments Are Like

In Chapter 2 health impairments were described as conditions that interfere with a child's growth and development, by preventing that child from participating in activities and learning experiences. The more severe the impairment the more limited the child's experiences are likely to be and the greater the potential is for problems in areas of development. For example, let us compare Sammy and Carol, two children with cystic fibrosis.

Sammy

Sammy has a very mild form of cystic fibrosis. Occasionally he has digestive upsets. He coughs frequently. He was hospitalized once for pneumonia when he was younger, but since then his parents and doctor have kept a close eye on him. When he does get an infection it is quickly treated. He is usually absent a week to ten days when he has a respiratory infection.

How would this level of impairment affect how Sammy learns?

Sammy's Level of Impairment

Sammy tires more easily than some of the other children, and he frequently coughs in active play. He needs to be encouraged to participate in gross motor activities, even though they increase his coughing. In fact, coughing itself should be encouraged, because it helps to keep his lungs clear of mucous. Strenuous activity or hot weather increase the loss of salt from Sammy's body, so he may need to take salt tablets on very active or very warm days.

Sammy seems generally confident of himself in the classroom, though he is sometimes hesitant about trying new gross motor activities. Sometimes he draws pictures of himself with his lungs drawn in. He says that his doctor once drew a similar picture to explain cystic fibrosis to him.

Sammy gets along well with other children. Sometimes he is shy around new children or adults, and they often avoid him because they are not used to the coughing or aware of its causes. But he is learning to explain that he coughs because he has cystic fibrosis and not because he has a cold or any other contagious disease.

Sammy's thinking and communication skills are developing like other children's. His health impairment has not limited his experiences enough to cause problems in thinking and using language. Sometimes his teacher talks with him and the other children about his health problem, hospitals, and doctors. But mostly she talks about everyday playing and learning activities, as she does with the other children. She is helping Sammy see that cystic fibrosis is only a small part of what makes Sammy Sammy.

Carol

Carol has a much more serious form of cystic fibrosis. She coughs continuously and is usually absent one or two days a week. She has had two prolonged absences because of pneumonia during the current year, and was hospitalized several times in the past. She must have postural drainage and aerosol inhalation therapy two to three times a day. These routines are done at home. Carol has to take numerous pills (as many as 20 to 30 pills each day) to aid her digestion and to replenish the salt her body loses. Clearly, Carol's opportunity for activity and experience has been very limited by her impairment. As a result, she has more problems functioning than Sammy does.

Carol's Level of Impairment

Carol cannot participate for long periods of time in many gross motor activities (such as running, jumping, and climbing) because her endurance is limited. She needs to be encouraged to do these activities as much as possible because they will aid her muscle development and coordination and increase the coughing necessary to clear her lungs. She can do quieter activities (such as walking balance beams, crawling through tunnels, and ball rolling) for longer periods of time without tiring. Carol's teacher tries to adapt as many activities as possible so that Carol can participate.

Carol had never been in a group of children before enrollment in Head Start. In fact, the only other children she had had contact with were her sisters and brothers, and a few children she had met in the hospital. When she first came to Head Start, she was very shy and fearful of the other children. Her shyness and the fact that she is sometimes irritable and short-tempered when she is not feeling well have made it hard for her to make friends.

Carol is self-conscious about her coughing. She is often afraid and tense during coughing attacks, and sometimes tries to stop coughing even though it is good for her. Her teacher has learned to be calm and relaxed during attacks so that Carol is not further excited. He reminds her that the coughing is important, and allows her to go into the hallway when she is embarrassed by it. He also has explained to the other children that Carol is not "spreading germs" but must cough because of a special problem. To help Carol improve her self-concept, he tries very hard to divert her attention from the impairment to her accomplishments in classroom activities.

Carol has not had many opportunities to experience things in her environment, so her understanding of many concepts is limited. For instance, before coming to Head Start, she could recognize a drawing of a circle, but she had not experienced standing, sitting, or moving in various circle activities.

Carol speaks very well and has a large vocabulary. Her parents read to her often, and looking through picture books is an activity she especially enjoys. But even though Carol uses many words, her understanding of the things the words describe is sometimes limited by her lack of concrete experience with those things. Carol's teacher plans short neighborhood trips to try to add to Carol's firsthand experiences.

Severity of Impairment

Sammy and Carol's limitations in what they can do are tied to the severity of their health impairment. The following chart on severity of impairment may help you consider how much program modification may be needed for a child in your class. The degree of impairment from child to child varies from mild to severe. The following chart illustrates four levels of impairment.

Severity of Impairment, the Child and the Program

	Level 1: Mild	Level 2: Mild to Moderate	Level 3: Moderate	Level 4: Severe
Is the Child Handicapped?	No	Possibly	Yes	Yes
How Does it Affect the Child's Functioning?	Health impairment does not interfere with day-to-day functioning and learning.	Health impairment does not interfere with learning, but there is a possibility of unusual episodes or crises.	Health impairment either presents frequent crises, or else so limits the child's opportunity to participate in activities that it interferes with learning.	Health impairment is so severe that special medical attention is regularly needed. The child's opportunity for activity is so limited that he or she may not be able to participate in a regular classroom.
Must the Program Be Modified?	No	No change in program planning is necessary. Be aware of the potential for unusual occurences. Report them to the parents or doctor. Know any first-aid procedures that might be required.	Activities will have to be modified to allow a health impaired child to participate. Staff must know proper first-aid procedures and be prepared to deal with children's questions about crises.	Extensive staff and program alterations are necessary to accept child into program. Home- or hospital-based programs may be more appropriate. Classroom support from medical services will be necessary, if child is in classroom.

Before discussing levels 1 through 4 in more detail, it is important to emphasize the following fact: children with health impairments do not always stay on the same level of impairment. The condition may worsen, it may improve, or it may even seem to disappear for a period of time. (Doctors call the apparent disappearance of a condition "remission.") As a result, it is necessary to reevaluate frequently any program you have planned for a health impaired child.

Level 1: Mild Impairment

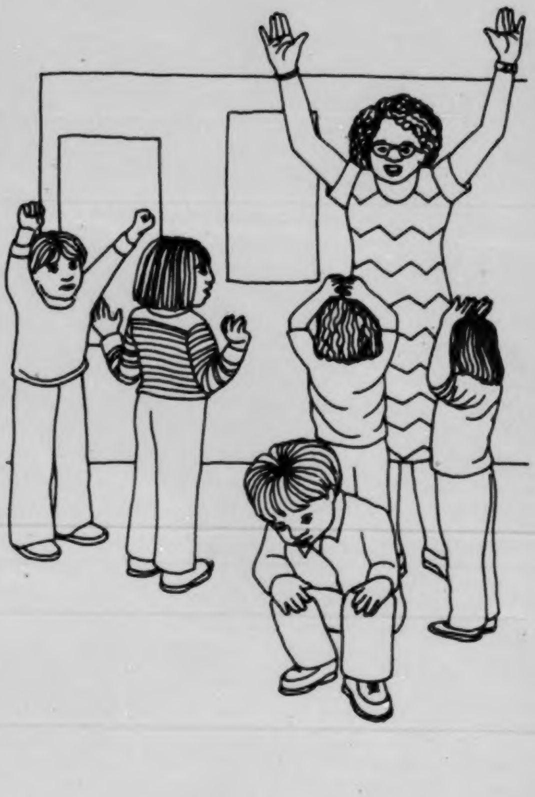
At this level, a child does not need to be limited in his or her activities. At the time of a child's admission and throughout his or her participation in your program, no additional or special efforts should be required of you. If there is a medical regimen, it is handled entirely by the child, the parents, and the physician.

It is very important, however, that you be informed of a child's diagnosis, and that you understand the outward symptoms of the impairment. If the child begins to demonstrate behavior that may be related to the health impairment, and that was not previously noticed, it may indicate a change in the condition. If you frequently observe new behavior of this sort, you should share these observations with the parents or health coordinator, who could raise questions about it with an appropriate specialist. The descriptions in this book of specific health impairments can be helpful to you in observing health impaired children.

It is not necessary for you to take the initiative in discussing a mild health impairment with the other children in the class. If the child chooses to discuss it, handle the situation as you would when any child offers information: neither suppress nor prolong the discussion. It is important that a child be able to discuss this aspect of him- or herself without causing more reaction than the child or other children feel it deserves. For example, a child with a repaired heart defect might say to another child, "I once had a hole in my heart." If the other child does not believe this, you simply need to say something like, "Yes, Billy did have a problem with his heart. But some doctors were able to fix it and it's not a problem anymore."

Level 2: Mild to Moderate Impairment

In addition to knowing that a child has a mild to moderate health impairment, it is important that you be aware of certain behavior that, although highly unlikely, may occur. For example, Benny, a child with a congenital heart problem, functions normally in every way and in all activities. One day you are supervising an activity involving gross-motor exercises, which Benny has done easily many times before. Suddenly you notice Benny stop and squat on his heels for a short time, after which he rejoins the exercise. This behavior is typical of children with such an impairment.



Usually at this level, a new behavior is not terribly significant. It may occur only once. In some instances, however, its occurrence may signal increasing complications in the child's health impairment. If the changes persist or increase in severity and frequency, you should share your observation with the parents to find out if they are aware of this behavior. It may be important information for them to pass on to the child's specialist.

Your program presents a child with a new environment, new and different activities, and new friends. This creates a change in the child's routine. As a result, new behavior may surface. For example, the classroom may present Marie, a child with diabetes, with many more opportunities for exercise than does the apartment in which she lives. This increase in exercise may have an impact on Marie's appetite and thirst. Again, at this level it is unlikely that new behavior of this sort requires any special action on your part. If you are concerned, however, you should ask yourself:

Was this day different in any significant way?

Did the child appear tired upon arrival?

Did the child have a cold or the flu recently?

Did the child appear to be tense or excited?

Was there an activity during the day that was unusual or exciting, such as a fire drill?

If you answer yes to any of these questions, chances are good that the behavior is a result of the situation described. If you are unable to find a reason, however, and still have concerns, it is best to raise them with a doctor, nurse, or parent, and be assured that the behavior is not a cause for concern or that it is being watched closely. There is always the possibility that you will be the first person to spot a new problem.

Level 3: Moderate Impairment

At this level, a child's health impairment is either continually obvious or obvious only during an episodic crisis. An "obvious" health impairment does not mean that the child with asthma, diabetes, seizures, or a congenital heart defect looks different. It means that the health impairment affects the child's behavior in such a way that the child is aware of his or her limitations. In most cases, the child's unusual behavior is also recognized by the other children in the class. Examples are coughing in children with cystic fibrosis, coughing and wheezing in children with asthma, and limited movement in children with congenital heart defects or sickle cell anemia.

At this level you can assist a child in understanding his or her limitations. The program must be designed to allow the child to participate in as many activities as possible. Specific program modifications for children with moderate impairment are discussed in Chapter 4 of this book.

The other children in the class will need your help in learning to understand and accept the child with a moderate health impairment. Ways you can help them do this are also discussed in Chapter 4.

The child's adjustment as well as acceptance by the class will be a concern of the child's parents. Chapter 6 discusses how parents and teachers can work together as partners.

If the health impairment is known to reflect itself in crisis-like episodes, it is important that you find out as much about these crises as possible. Consider the health impairment of epilepsy. Lamont is a youngster in your class who has about one grand mal seizure per month. His seizure lasts for approximately 30 to 45 seconds. During the seizure you should protect him from hurting himself, but you should never attempt to stop the seizure. Lamont regains consciousness within one to two minutes, and is able to return to class activity after a short rest. Sometimes he wants to sleep for 30 to 45 minutes following the seizure. You should allow him to do this in a quiet place. It is important that other children be reassured that you will take care of Lamont during this time. Instilling in other children a healthy outlook and attitude toward his health problem is important for Lamont, too.

Contrast Lamont to Roxanne, a youngster who experiences between 20 to 30 petit mal attacks or momentary lapses per day. There is no motor involvement in the attacks, so she need not be protected from falling or injuring herself. However, due to the frequency of the attacks, it is very difficult for Roxanne to carry out activities that require sustained attention. Lamont and Roxanne are both able to participate in your program. But you should know proper first-aid procedures (see the bibliography, or ask your program's nurse) and you will need to establish a reporting system so that you, the parents, and the doctor are kept informed of the children's behavior patterns.

It is important to keep records of when particular behavior occurs, and to watch for any significant patterns. For example, do seizures occur after certain kinds of games, prior to or after snack, or after a specific activity? This kind of information can be very valuable not only to the parents and doctor, but also to you in planning for the child. Also, sometimes a child's need for medication can change. Since it often takes some time to develop a new program of medication for the child, you may be asked to keep very careful records of a child's behavior during such periods in order to help the doctor determine what and how much medication is needed.

Level 4: Severe Impairment

A child with a severe health impairment requires a great deal of attention. Usually this child is under constant medical supervision and must follow a strict treatment regimen. Probably you would have to make significant alterations in your program, increase your staff, and establish close cooperation with medical specialists, before admitting the child to your program.

Medication and Emergency Situations

Medication

Many children with health impairments must receive medication daily to control their conditions. For instance, the diabetic child needs daily injections of insulin; the child with cystic fibrosis needs enzyme and salt supplements; the child with seizures needs anti-convulsant drugs. Health impaired children may need to take antibiotics more often than other children to prevent and control infections. Usually these drugs can be administered at home before and after preschool, although in some instances the Head Start program has to arrange to administer them at the center. The following is Project Head Start's policy on the use of medication in Head Start programs:

> **Whenever possible, arrangements should be made with the family and the physician to schedule administration of medication during times when the child is most likely to be under parental supervision. Otherwise it is the responsibility of the Head Start director or his designee to supervise the administration of medication in accordance with state requirements as to specific personnel who are designated to dispense drugs and be accountable for them. In addition, over-the-counter drugs (e.g., aspirin, nose-drops) should be administered only by personnel who are knowledgeable about their use and side effects. Other drugs must not be given unless they have been prescribed by a physician for a particular child. All medication must be adequately labeled. Drugs must be stored out of the reach of children and prescription medications must be kept under lock and key. Before any medications are administered, recorded parental consent must be on file. Special precautions are of particular importance when treatment for a specific handicapping condition requires administration of potentially harmful drugs (e.g., anticonvulsants, amphetamines).**

(Transmittal Notice, Head Start Policy Manual 2/28/73, pp. 9-10.)

What You Should Know

1. You should always be informed when a child begins to take a drug, and when the dosage is changed.

2. You, the child's parents, and any other person responsible for giving the drug need careful instructions about how, when, and how much to give; the side effects to watch out for; and the expected effects on the child's behavior.

3. You, the child's parents, and the doctor must keep in close touch with each other to compare notes about how the drug is working. You may be asked to keep very careful records of a child's behavior when medications are being evaluated or changed.

4. You should know whom to call with questions (usually a nurse, or the child's own doctor) and in case of emergency.

5. The drug must be kept in a safe place at home and the parent must be truly reliable about giving the recommended dose at a regular time. Nothing is more confusing to a child or his or her teachers than to take a drug irregularly. One day the child seems well and able to participate; the next day the same child feels bad and is unhappy with everything and everybody.

Measures to Take in Emergency Situations

One characteristic of many of the conditions described in this book is the periodic occurrence of crises. Examples of crises are seizures in children with epilepsy, severe coughing in children with cystic fibrosis, coughing and wheezing in children with asthma, and insulin shock in children with diabetes. After discussing these problems in general, this section goes on to describe first-aid procedures for handling the most serious of these crises.

Preparing for Crises

Your role as teacher is to help children with impairments perform up to but within their limits. It is difficult to achieve this level of performance without exceeding a child's limits at some point. The fact that a child has an episodic crisis does not indicate that a teacher has failed, nor does it mean that the entire program requires modification. An epileptic child may participate many times in a particular activity with no trouble, then suddenly go into seizure one day while doing the same activity. Many factors (such as diet, rest, emotional state and illness) may contribute to the onset of an episodic crisis. Whenever a crisis occurs, you should notify the child's parents and/or doctor.

If a crisis occurs unexpectedly, think back about the child's behavior just before the attack. This can help you find clues that indicate the possible onset of a crisis. This information should be shared with the child's parents and/or doctor. Once a child has recovered from a crisis, have a private discussion with him or her.

Ask:

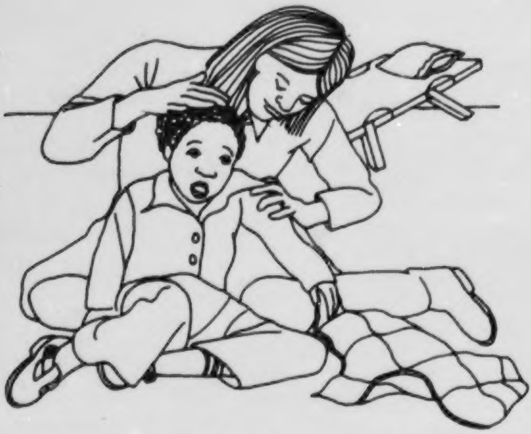
Was this time different from other times?

Did you know that a crisis was about to occur?

Would you be able to tell me next time before the crisis occurs?

Assure the child that you would like to help with the problem in any way you possibly can.

Despite all efforts, for some children crisis episodes are simply unavoidable. It would be unrealistic to expect to be able to eliminate their occurrence. It is also unrealistic for the parents to think that you can. Most parents won't expect this of you since the child occasionally has episodic crises at other times and places, including the home. What you can do, however, is be prepared to handle crises when they occur. You should prepare the other adults in the room to be of assistance to you. You should also make sure that the other children in the classroom are aware that a crisis may occur, so that the impaired child will find a climate of understanding and support, rather than distress.



A child may need reassurance following a seizure.

You can mention the fact that a crisis may occur when you discuss other types of emergencies (such as before or after a fire drill). Keep your explanation simple, and make sure the children understand that you and the other staff members will handle it—just as you handle any emergency. You might also consider reading or telling a story to explain a particular type of crisis.

In order to prepare yourself for crisis episodes, talk to the parents or to the child's doctor. Ask them to:

- describe the reporting system to be used between you and them regarding the crisis. How should you maintain contact with them?
- specify things they would like to have you record in your written observation of the crisis. Is it important to note the time that it occurred? Is the duration of the attack important?
- describe to you anything that may cause a crisis.
- describe to you how often any such event is likely to occur.
- describe to you how the child may behave before such an event. Specifically, does the child know when he or she is likely to have a crisis? How will the child try to tell you?
- describe for you what the child is like during the crisis. What behaviors does the child demonstrate? How long does the crisis usually last?
- describe for you what the child is like after the crisis. Is the child scared, tired, or disoriented?
- describe, demonstrate, or train you in what you are to do during and following the crisis. Can you do it alone or should you summon help?
- inform you of any activities that must be avoided. Doctors call these activities **contraindicated.**

First Aid

First aid is the immediate care given to a child who has been injured or who suddenly becomes ill. It is important to be prepared not only to take the correct actions to assist, but also to do them in a way that will not frighten either the injured or ill child or the other children in the class.

Children with health impairments suffer the same types of bumps, bruises, cuts, headaches, and falls that all other children suffer. In addition, they may have special emergency problems that are related to their health impairment.

So that you can handle general problems quickly and well, *review* simple procedures frequently. Use any first-aid book to help you do so. (An excellent first-aid book is listed in the bibliography in Chapter 7.) Know what to do *before* something happens. You should know the following treatments, for example:

- Small burns are treated with ice.
- Cuts are held firmly with clean material (cloth, paper), until the bleeding stops.
- Bloody noses are best treated by pressure on the outside of the nose and by keeping the child quiet.
- Falls are handled by keeping the child **where he or she fell** until you feel reasonably sure no bones are broken. First ask the child if there is pain anywhere. If there is none and the child can move his or her body, chances are nothing is broken. If the child has pain in a particular area, carefully check for obvious signs of a problem, such as redness and swelling. Refer to a first-aid manual at this point, and follow directions carefully.

All teachers who work with children should have first-aid training, if at all possible.

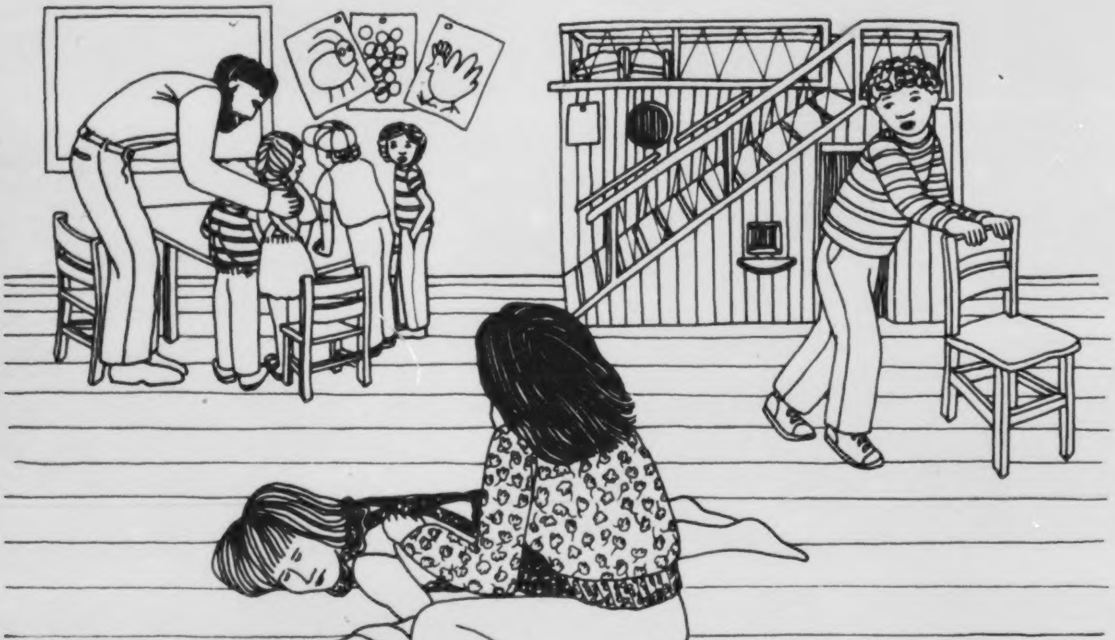
The most common emergency problems related to health impairments are seizures (fits or convulsions), bleeding in a child with hemophilia, and shock in children with diabetes. You may feel helpless or panicked when such crises occur. This is normal. You can help yourself and others in these situations if you have studied the proper procedures in advance. Review these procedures with a child's parents and doctor, and have this information readily at hand to remind you what to do. Also have a list of phone numbers to call—and a plan to follow if people can't be reached by phone.

Seizures

Seizures are best handled by allowing the affected boy or girl to remain where he or she is when the seizure begins, or to gently lower the child to the floor. Make sure that the child doesn't injure her- or himself against things in the room when jerking. A seizure *cannot* be stopped; therefore ***do not try to stop the child's jerking and do not put anything in the child's mouth.*** If the child is known to have a seizure problem, proceed with the plan you have worked out ahead of time with the doctor and the parents. If this is the child's first seizure, ask for the nurse's assistance via phone or messenger. If the nurse is not available, call another adult to assist with the other children while you attend to the child with the seizure. If the jerking does not stop within two to three minutes, call the child's parents and/or doctor. If the child has two grand mal seizures, one right after the other, this could signal a medical emergency. Call an ambulance immediately to take the child to a hospital. This type of emergency happens *very rarely*. If you are asked to transport the child, two adults can easily carry him or her suspended in a blanket or in their arms. If the child is being carried make sure the chin is *not* down on the chest—the head should be back and the jaw pulled *forward*.

Do not give any medicines by mouth to a child having a seizure. When the jerking stops, the child may want to rest for a few minutes to a few hours. This sleep is natural and should be allowed.

Seizures are not painful and do not "harm" a child. Actually, a seizure is probably more frightening to the people watching it than it is to the child who is having it, because during the convulsion the child is unaware of what is happening. Afterward, however, the child may be frightened by the realization that a seizure has occurred. You may wish to spend some time talking privately with him or her. The discussion will allow you to give reassurance and support to the child, and will provide an opportunity to seek some clues as to why the seizure took place.



36 Bleeding

Children with hemophilia seldom have major bleeding problems that require emergency first aid. They bleed the same *amount* as other people, but they don't *stop* bleeding. You will be told if a hemophiliac child is enrolled in your class. You should be able to prepare ahead of time for handling cuts, bruises, and other injuries.

Ordinary cuts in these children do not "gush" blood. They just continue to bleed when you take pressure off them. However, a band-aid, firmly applied, stops the bleeding. This is because minor injuries open only the small blood vessels near the surface of the skin. Pressure closes these vessels.

Deep cuts are obvious problems. They require pressure with clean material until the child is seen by a doctor. Ice and pressure can't hurt a child unless the ice is "too cold" and hurts. If the child complains, wrap the ice in a towel or other material to lessen the cold.

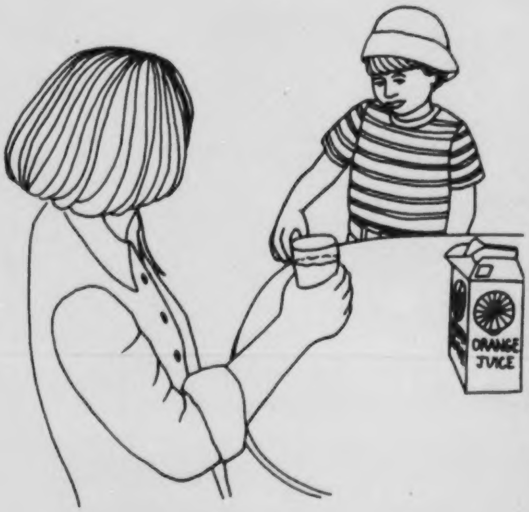
Following a heavy fall, blow, or any head injury, a child with hemophilia needs medical attention. Place a cold towel on the injury and allow the child to rest until transportation to a doctor has been arranged. If the child complains of a headache or pain in the throat, there may be a genuine crisis. The chances of this happening are very slight. However, should this ever occur, parents and a doctor must be notified immediately.

Insulin Reactions

You will be told ahead of time if a diabetic child is enrolled in your class, and should be prepared for handling insulin reactions. A diabetic requires at least one injection of insulin per day to assist the body in turning sugar into energy. If insulin isn't available, the body does two things that are abnormal. First, the sugar that can't be used is passed in the urine, drawing much water along with it. Second, the body burns fats and proteins instead of sugar for energy, which creates excessive acids and other materials that overload the body.

When the body gets ***too little insulin,*** the child becomes sleepy, breathes quickly and deeply, has abdominal pain, passes much urine, and has a sweet (acetone) flavor to the breath. These problems build up over hours to days. They are usually not emergencies.

When the body gets ***too much insulin,*** the sugar is used up very quickly. The child feels weak, trembles, sweats, is confused, and may have a seizure. If the child is alert and awake enough to eat or drink, give him or her some sweetened juice. Do ***not*** give anything by mouth if the child is not alert and can't adequately chew or swallow.



Chapter 4:

Mainstreaming Children with Health Impairments

4

In the mainstream classroom each child is different and every child is alike.

Until fairly recently, children with severe health impairments were placed in special programs with other handicapped children. This exclusion from regular programs made it difficult, if not impossible, for health impaired children to accept themselves as part of a world that emphasized "normal." It made it equally difficult for non-handicapped children to learn about and accept children with health impairments. In the mainstream classroom, all children can develop a better understanding of the many ways in which each child is different and every child is alike.

Project Head Start stresses that all handicapped children, regardless of the severity of their handicap, should be considered for enrollment in Head Start if the particular program can meet their needs adequately. Both the resources within your program, including available staff, and the resources in your community determine what you are able to offer children. This means that you, the total Head Start staff, and the appropriate specialist(s) should decide together with the parents of a seriously health impaired child whether that child should participate in the program.

Not every child can benefit from a mainstream program. In some cases, the impairment is so severe that a Head Start program cannot adequately meet the child's needs, despite community resources or specialists' help. There may be instances in which the emotional needs of a child are so great that it is self-defeating to attempt to mainstream the child. If the distance between a child's home and the program is so great that the child is exhausted by the travel involved, the child won't be able to benefit from the activities of the program. And if having their child in a Head Start program causes the parents anxiety, you might suggest that they discuss their concerns further with social services staff.

The Teacher in Mainstreaming

In mainstreaming a child with a health impairment, your first responsibility is to *be the child's teacher!* As with all other children, you bring your training and experience into your work with the child, and view him or her as a *learner.*

Second, you must be willing to build upon your professional training in a variety of ways. You may need to find and read information about the health impairment. You may need to work with other professionals, such as physical and occupational therapists, speech pathologists, audiologists, ophthalmologists (see Chapter 6 for a description of what these and other specialists do). The opportunity to work with specialists can be a learning experience. What you learn from them may help you plan individualized programs for all of your children, not just those with health impairments.

Third, you need to accept and support each child. All children need your understanding of their intellectual capabilities and limitations, of their relationships with their parents and their needs for special considerations. Children need to view *you* as the person who is there to help them learn about the world in which they live and about how they function within it.

Finally, you must trust your own judgment, your knowledge of children, your skills in working with parents, and your ability to work with other specialists. This will enable you to plan and implement a curriculum that will allow each child to develop as an individual.

4

Planning

The planning process for a child with a health impairment has the same purpose as for other children: to help you map out a course of action for working with the child. This process calls for the involvement of several people: the teacher, the parent or parents, Head Start staff representing the various service components, and service providers from outside agencies.

The goal of the planning process is to produce an **Individualized Education Program** (I.E.P.) for the child, which is now required by Public Law 94-142, Education for All Handicapped Children Act, and required by Head Start Performance Standards. Based on an evaluation of the child, the Individualized Education Program states the child's present level of educational performance, the annual goals and short term instructional objectives for the child, and evaluation procedures for determining whether instructional objectives are being achieved.

For each handicapped child, Project Head Start requires the following elements in the planning process:

1. An interdisciplinary team is required to make two kinds of diagnoses: a ***categorical diagnosis*** and a ***functional diagnosis.*** A categorical diagnosis is simply a statement of the kind and severity of the child's handicap. This kind of diagnosis is useful to you only for reporting or record-keeping purposes. The team also should develop a functional diagnosis, or assessment, which is useful to you in your classroom planning and teaching. It is a developmental profile that describes how the child is functioning, and that identifies the services the child requires to meet his or her special needs.

2. Based on the functional assessment, an ***individualized education plan*** is to be developed for the child. This plan describes the child's participation in the full range of Head Start services, and the additional outside services that will be provided to respond to the child's handicap.

3. Periodically, ***ongoing assessments*** of the child's progress are to be made by the Head Start teacher, the child's parents, and (if needed) by the full diagnostic team. If these re-evaluations show that the child's individualized education plan or the services he or she is getting are no longer appropriate or needed, they should be changed or adjusted.

4. When the child leaves the program, Head Start should make arrangements for the ***continuity of needed services*** in elementary school. This can be done in a variety of ways, but usually involves holding a conference with parents, the school, and service providers. The elementary school should be given a description of the services the child has been receiving, recommendations for future services, and the child's records from Head Start.

As the child's teacher, you are involved in many of these procedures. Your part in the process is described in more detail in the following six steps. These steps are just as useful with non-handicapped children and other handicapped children as they are with a health impaired child.

Step 1: Observe each child in a variety of activities, and record your observations.

Step 2: Set objectives based on what you have observed as reasonable for the child to achieve.

Step 3: Select classroom activities and teaching techniques that can best help each child reach the objectives. Seek outside assistance as needed.

Step 4: Develop the plans with the child's parents and specialists.

Step 5: On a continuing basis, observe, evaluate the child's progress, and develop new objectives.

Step 6: When the child is ready to leave Head Start, make plans to ensure that there is continuity of needed services with the public school.

Each of these steps in the planning process for handicapped children is discussed in greater detail below. For help in individualizing your activities for health impaired children, see the section titled, "Activities," pp. 56.

Step 1:

Observe

The process and purpose of observing is the same for all children. The purpose of observing a child is to identify the child's **developmental level**—the level at which the child is actually functioning. This can tell you much about the child as an individual. Progress is made by building on the child's strengths and working on areas that are weak. As you observe the child in a variety of activities, you should take careful notes. Another name for this process is assessment, or evaluation. Evaluation is particularly necessary and useful to the planning process because it makes you aware of the basis for what you do in the classroom.

How To Observe

Observation is a technique of focused looking and listening to what people say and do. Using observation as a tool for learning about children involves being systematic, watching for patterns, and using the information.

Be Systematic

There are some general tips that can help you be systematic as you observe.

1. Note details

It is very important to write down specific, detailed observations that focus *exactly* on what the child does. For example, if you write down, "Albert fell down a lot today," this might mean that he wasn't paying attention to where he was going, was awkward, had a problem with his leg muscles, or a number of other possibilities. However, consider this version: "Albert fell down once this morning in the classroom. This afternoon, toward the end of the program, he fell several times." These notes, together with a discussion with a specialist, may lead you to conclude that Albert is getting too tired in preschool. He may need to be less active, or the specialist may suggest changing his medication.

For information to be useful it must be specific.

2. Write down the details as soon as possible

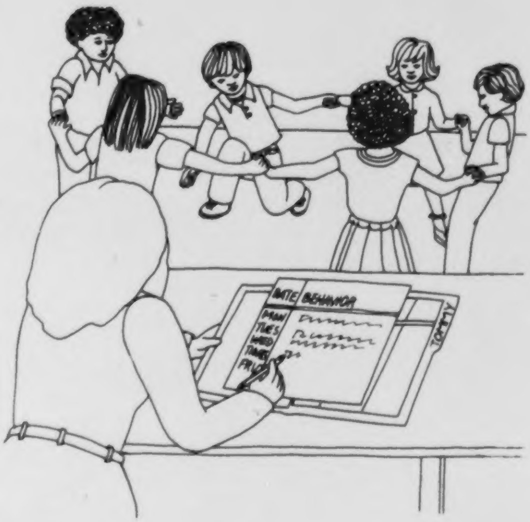
Write down what you see as soon as possible, since it's easy to forget quickly the details of a child's behavior in a particular circumstance. Details are important: they describe a child's individuality. They are also the best indicators of a child's strengths and weaknesses. When you make notes, try not to be obvious about it. Write them down away from the child.

3. Plan a realistic schedule

Your observations should be scheduled, just as your activities are. Observe and make notes as often as necessary to get a full picture of what the child does easily and has problems with in the skill area you are focusing on.

4. Vary the settings in which you observe

Children can behave differently in different activities and moods, so it's important to observe a child in a variety of situations. Observe the child on the playground and in the classroom. Observe the child as he or she plays alone, with other children, and with you and other adults. Observe the child when he or she is feeling happy, sad, tired, rested, friendly, and angry, because these feelings affect the child's behavior.



5. Vary your observer role

You might also try to vary your role as an observer. You can act as a spectator-observer, watching but not participating. For example, you can observe from the side of the room while another adult manages the classroom activities. Or you can be a participant-observer, taking part in the activity with the child. It is usually easier to observe as a spectator, so you might try this method first. Again, be careful not to call attention to yourself as you observe, otherwise the child might not act naturally.

6. Start by observing one child at a time

As you become more experienced in observing, you will probably find that you can observe more than one child at a time. It's best not to try to do this, however, until you are pretty sure you won't get confused, or miss or forget important information.

Watch for Patterns

Watching for patterns is an important part of observation. You may notice that a child sometimes forgets words, stumbles, and knocks things over. All preschool children do these things from time to time. What you want to know is whether the child often or always does these things. Carry a piece of paper and a pencil around with you and keep track for a few days. Be sure you are objective (factual) about your observations—try to keep your own feelings and reactions separate. In this way, you will be able to see the patterns that point to the particular skills with which the child needs help.

During activities that call for talking, such as during free play or story time, observe how the child speaks and the ways in which the child talks with adults and other children. Watch for patterns to appear. Does the child use speech you would expect to find in a much younger or older child? Does the child seek out other children, or does the child seem hesitant in approaching others?

In circle games, watch how the child uses his or her body, arms, legs, and hands. Note patterns of clumsiness: does the child stumble, fall, or trip? Is the child's balance poor? Does the child tire easily? Does the child know when to pause and rest? Is the child hesitant about trying new activities?

When playing with table activities such as blocks or puzzles, other patterns may emerge. Does the child knock things over when reaching for them? Are the child's eye-hand movements coordinated? Can the child grasp and hold small objects such as pencils or crayons? Can the child cut with scissors? Can the child match and sort out pictures, objects, shapes? Are such activities too difficult, or are they unfamiliar to the child?

In quiet activities, does the child listen and watch, or does he or she try to get up and move around?

Watching for **patterns** is very important but they are sometimes hard to see. Going back over all the notes you have made can help you to discover patterns you didn't see before. You should review your notes on a regular basis. The information in them can help you identify new skill areas and behavior you might want to find out more about, either by observing or by other assessment methods.

Use the Information

Once you have observed a child systematically, written down your observations, and reviewed your notes, you should be able to identify areas of strength and weakness in the child's skills. This information can be used to develop objectives for the child, and to select activities and teaching techniques that meet the child's needs. This information also becomes a basis of discussion with other staff, parents, and specialists.

Step 2:

Set Objectives

An important part of the planning process is developing individual objectives that will lead to the maximum growth of each child. The objectives need to be realistic in terms of the purpose of Head Start and the program's staff and time resources. Most important, the objectives should be developmental objectives. In other words, you can't expect to make a severely health impaired four-year-old function exactly like non-handicapped four-year-olds, but you can help the child progress to his or her next developmental level.

Here are some guidelines for setting objectives.

1. Be specific

When you have gotten together your observations, you will find some areas of strength and some weaknesses. This information is not particularly useful until it is translated into what the child *needs*. State objectives in terms of skills and behaviors that need to be learned and that you can observe. Set a target date for the achievement of each objective. For example, if Aiko has difficulty getting along with others, your objective for her is to learn to take turns in group play. To make this objective more specific and easier to observe, state it as follows: "In two weeks, Aiko will wait for her turn in line for London Bridge Is Falling Down."

2. Develop both long- and short-term objectives

If Abraham has difficulty with gross motor skills such as jumping and hopping, the long-term objective for him might be: "Abraham will learn the gross motor skills of jumping and hopping." Short-term objectives that will help Abraham meet the long-term one are: "In two weeks, Abraham will jump in place after demonstration by his teacher. In three weeks, Abraham will jump in place without demonstration. In four weeks, Abraham will hop on one foot after demonstration by his teacher. In five weeks, he will hop on one foot without demonstration."

Assume everyone can participate. Modify an activity only when necessary.

3. Develop new objectives as needed

Objectives will have to be changed if your observations show that there is a need for it. If Abraham surprises you and learns to jump in place in only two weeks instead of three, or if it takes him more than three months to jump in place, you will want to develop new objectives to fit Abraham's abilities and needs.

Step 3:

Select the Program, Activities, and Techniques

If your Head Start program has several program options, you need to consider which one can best meet the objectives you have set for each child. For some health impaired children, a full-day center-based program is best. For others, a part-day program combined with a home-based program or a special class might be best. The particular combination of Head Start and other services that is best and the amount of time spent in each varies from child to child. It is a good idea, however, to start off by *expecting* the child to participate in *all* standard Head Start activities along with the other children. The child's program can then be revised, if and when it becomes necessary.

To make it possible for health impaired children to participate in all your usual classroom activities, think about ways to adapt them, and prepare them differently. You can use a variety of teaching techniques to make sure the child gets what he or she needs. For examples, look at the activities in this chapter.

Step 4:

Develop Plans with Parents and Specialists

Parents

Sometimes it is hard for parents to recognize changes in their child from day to day. In the classroom you have the opportunity to see a child for long stretches of time, to observe the child performing a wide variety of activities, and to compare each child with many other children. For these reasons, you can observe a child's daily progress and set realistic objectives based on your observations. On the other hand, parents know a great deal about their child that no one else can learn simply by being the child's teacher. Moreover, for education to be effective, parent and teacher goals for the child need to be consistent so that both are working, in their different roles, toward the same end. Develop your plans with parents. Share with parents the progress their child is making in your classroom and ask them to share with you the child's accomplishments at home. As you work together with parents, you might invite them to observe the program and to assist in class activities.

Specialists

Specialists typically see a child for short periods of time doing a limited number of tasks, and interacting only with themselves and the parents. Sharing your observations with specialists can provide them with valuable information on the child's activity in a more normal setting. In turn, the specialists can help you understand what limits the handicap imposes on the child's activities, and may be able to help you develop objectives that are based on the child's needs and abilities.

Step 5:

Continue to Observe, Reassess, and Make Adjustments

While a formal assessment of each child's development and progress may occur only once a year, you should aim for more informal evaluations much more often. (Remember how quickly children change at this age, especially in a stimulating Head Start classroom!) As you observe and record regularly a health impaired child's responses in major skill areas, your understanding of that child and the effects of the impairment will grow. Keep in mind the objectives toward which the child is moving, and how much progress has been made.

Refer often to your past observations, and look for patterns in skill areas. If, for example, there is a pattern of poor eye-hand coordination, consider whether you have seen some improvement in this area. Try to figure out which activities the child has enjoyed most and which ones seem to have caused the most improvement. Try to include more of these kinds of activities in the future.

Step 6:

Continuity Between Head Start and the Public Schools

As a result of the Education for All Handicapped Children Act, public schools will increasingly be providing the benefits of mainstream classrooms and special services to handicapped children. After being in a mainstream Head Start classroom and receiving special services, children with health impairments will need to have these advantages continue. There are several things a handicap or social services coordinator and you can do to contribute to the continuity of the education that a health impaired child in your program has been receiving.

- **Some Head Start programs have developed formal relationships with the public schools in their areas, to assist in the transition between preschool and elementary school. If your program has no formal relationships with the public schools, you might explore the possibility of establishing them. Your program director or handicap coordinator will know where to go for suggestions on how to achieve this.**
- **Developmental continuity is made easier if community providers of special services to Head Start children continue to provide them to children as needed when they go on to public school. Before a child leaves Head Start, you can discuss the child's future plans with the specialists who have been working with him or her.**
- **Parent participation in the services their child has been getting in Head Start is a valuable foundation to build on. Encourage parents to continue their involvement and to make sure that their child receives needed services in elementary school.**
- **Finally, you can keep in touch with the child and his or her family after the child leaves your classroom. A telephone call or a visit to find out how things are going will be appreciated by the parents. If the child is having problems, your suggestions on how to deal with them would be welcomed.**

Everyone needs to get away from it all once in a while.

4

The Physical Setting and Classroom Facilities

Head Start programs across the country each have different classroom facilities, and few of them have ideal physical settings. While modern buildings, fancy furniture, and expensive materials often seem important, they rarely are required to provide a stimulating learning environment. The children and the staff really make any preschool program.

By and large, most handicapped children *don't* require special classroom arrangements or extra materials. You can adapt and reorganize the materials you already have to meet the needs of most handicapped children, including those with health impairments. Basically, the classroom should be arranged to suit the ways you use it every day, with modifications to suit the special needs of a handicapped child. These modifications should not be necessary very often, and they are usually minor.

There are moments when handicapped children need special help in dealing with the physical setting of the classroom. Such help should be given freely. In general, arrange your room so that each child can explore the space and use the materials with as little assistance as possible. Following are some suggestions that are useful with all children, but are particularly helpful with children with special needs.

Clear Traffic Patterns

Make sure that your room is free of obstructions. The traffic patterns between activity areas should be easy to recognize. Making a map of your floor plan before the beginning of the program year may help you to recognize and correct traffic problems before they happen. Don't overlap traffic routes and activity areas—this will disrupt the children who are involved in the activities.

Start Simple

Keep your room arrangement as simple and uncluttered as possible, especially at the beginning of the year. As the children get used to it and learn to handle a more complex environment, you can gradually increase the amount of materials and number of activity areas. The use of well-defined and consistent space patterns will avoid confusion and help the children become familiar with the classroom organization. The space in which each activity occurs should be clearly marked.

For example, you might want to put masking tape on the floor to indicate the big block area and the housekeeping corner. Other space cues, such as cabinets and moveable partitions, can be moved around as needed. Mark storage areas clearly. Make sure children know where they are and what belongs in them, and can get at them easily. Be consistent about where materials are kept and where activities take place.

Noise Level

Avoid placing noisy activities next to quiet activities. Noise and movement distract some children from quieter tasks, and interrupt the rest breaks that some handicapped children need to function happily. Listening and speaking are a lot easier for everyone when it's relatively quiet. Be sure there are quiet places in the room, perhaps sectioned off. Rugs, curtains, and pillows can help keep noise down.

Individual Space Cues

Some children aren't used to sharing a room with a lot of other children, and they may use more than their share of the space. You can use physical signals to limit their movement. For example, a child sitting in a circle might extend his or her legs and kick the next child. To avoid this, try a masking-tape "x" or a rug square on the floor where the child is to sit. A file cabinet or a bookcase can be strategically placed to define the space you want a child to occupy. More subtle cues, such as a friendly touch or placing a disruptive child directly in front of you, will also help to limit the children's movement.

In general, the more obvious the space cue, the easier it is for the child to understand. As the children learn to use space properly, you can gradually eliminate the more obvious cues (rugs, tape), and substitute less obvious ones (a spoken reminder).

Even the spoken reminder will no longer be needed when the child learns and accepts the limits of his or her own space.

Personal Places

We all need to get away from it all every once in a while. There should be a quiet place available where children can go on their own. Some classrooms have cubby areas where children keep their personal belongings. These are sometimes large enough to be used as nice "escape hatches." You can even rig up a curtain that can be drawn across the cubby area, if the child would like this. Try to arrange your book area so that it is soft and comfortable, and has private nooks and crannies.

Health impaired children often need rest periods throughout the day. Providing quiet areas for all children will make this need less noticeable by allowing each child to take rest breaks whenever necessary.

Use What You Have

You don't need expensive or fancy materials for a child with a health impairment. You can often adapt what you have by thinking about what the child needs to learn from the materials. Watch the child to see if the materials are too complicated. If they are, the way the child reacts will let you know how to simplify them.

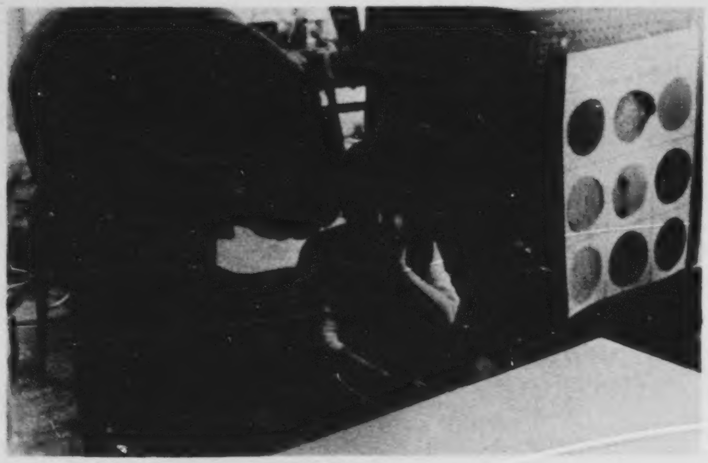
You might ask a handicapped child's parents for help in adapting classroom materials. They may be helpful in modifying both materials and equipment for their child, and can share their ideas with you.

Try to use materials that will stimulate children's curiosity. Offer materials that need active fingers and hands, and that allow a variety of uses. Since learning takes place through all the senses, include materials that a child sees, hears, feels, smells, tastes, and moves.

General Teaching Guidelines

There are many good ways to teach. Because of your personality, temperament, and values, you have developed your own individual teaching style, which is reflected in the activities you choose, and in the ways you interact with children. Good teaching techniques are often the same for the education of any child, whether handicapped or non-handicapped. So it is best not to try to change your natural teaching style for a child with a health impairment. It will only serve to make both you and the child uncomfortable.

With health impaired children, you will want to apply your teaching skills consciously, using those skills that most effectively serve the needs of the child. You do much the same for every child. Since children who are handicapped have problems that seriously interfere with development, they require extra consideration. Below are some basic principles that you may already know and use with all children. They are particularly useful in working with children who have handicaps, including health impairments.



1.

Understand Your Feelings and Keep Trying

Some adults are nervous and worried about working with a handicapped child for the first time. This is a typical reaction when they don't know the child very well yet (if at all). As a result they sometimes start out thinking of the child as, for example, an *"epileptic* child." As they spend time with the child, watch the child, play with the child, and hug the child, they usually find that they have begun to think of the child as a *"child* with epilepsy," and soon they think of him or her as a *"child,"* plain and simple.

Your first efforts with a child may not all be successful. This is to be expected. You may feel frustrated and guilty. If something goes wrong (as things do from time to time), figure out what happened, and remember it for next time.

Don't expect miracles. No one is asking you to cure a child, or to make him or her the fastest puzzle-doer in the class, or the best runner or climber. Sometimes, even with the very best help from you, other staff members, parents, and specialists, a child just doesn't make as much progress as hoped.

2.
Classroom Personnel

Aides and volunteers play a key role in all Head Start programs, and they should be included in classroom planning for children with special needs.

Aides

Your aide or assistant helps you teach activities and work with children individually. This help is especially valuable if you have a health impaired child in your class who needs special attention and assistance. Aides should be included in developing educational objectives for the child and in ongoing planning. Both you and the aide should agree on what the aide should do, and *why,* to help the child learn and play with other children.

It is not a good idea to have the child work constantly with only one adult. This isolates the child from other children, defeating the purpose of mainstreaming. Some children, however, will need the security of an attachment to only one adult in the classroom before they are able to work with several adults. For that child, you may want to assign an aide to work with the child for a while.

On the other hand, problems can be created when a child has too many caregivers who come and go. This makes it hard for the child to form emotional attachments. Children learn better with the reassuring presence of a few people they know and care about.

Care for the child should therefore be shared among a few adults and individual attention should be limited to what the child needs so that he or she is not separated from the group too often.

Volunteers

Volunteers can be helpful in working with handicapped children even though their work hours are probably shorter and less predictable than those of aides. They, too, need explanations and directions from you about what they are requested to do.

Parents make good volunteers. High school and college students are also ideal volunteers. Young people who are learning about children in school are often interested in working with them. Another source of volunteers is senior citizen clubs or apartment complexes for the elderly. Many elderly people, especially those whose grandchildren don't live nearby, would be pleased to help with young children—and they certainly are experienced! Other excellent sources of volunteers are organizations and agencies in your community that work with handicapped children (such as Easter Seal, United Cerebral Palsy Associations, children's hospitals, rehabilitation centers).

See to it that everyone who works with a handicapped child in your class gets along well with him or her. We all work better when we enjoy what we are doing.

3.
Setting Limits

Some limits must be put on children to protect their physical safety. Safety limits are usually clear-cut: for example, "We walk in the classroom" and "Look both ways before crossing the street." State safety limits simply and frequently, and demonstrate them when necessary. Enforce them consistently, so that children will learn that they must be followed.

Children also need limits to help them control their behavior. Unlike safety limits, behavioral limits require you to make some judgments about what is appropriate and what is not. Each of us has a range of child behavior that we accept or can tolerate in our classrooms. (Some teachers don't mind a lot of noise or a messy paint area, while others can't stand this.)

Whatever behavioral limits you set, be consistent in enforcing them. If the limits keep changing, the children will never know what you expect, and will not learn what you are trying to teach.

Praise children for their efforts, and try to ignore borderline but tolerable behavior. Let the children know that you accept and respect them, whatever the quality of their performance. As a result, the children will not feel personally threatened by failure. They will approach learning without fear.

Before setting a behavioral limit, look carefully at the behavior you are concerned with, and ask yourself the following questions.

How Does It Affect the Other Children?

Does the behavior disrupt the learning of the other children? If the behavior does not disturb the other children, then perhaps it is something you may want to learn to live with.

For instance, a child may want to lie down to listen to a story, even though you like the children to sit in a circle. If the child's need to lie down does not concern the other children or disrupt the story, perhaps this behavior can be accepted.

Can the Child Help It?

Does the child have control over the behavior? For example, you may find the coughing of a child with cystic fibrosis difficult to tolerate. You can teach the child to use a tissue, but you should not try to change this behavior, because the coughing is necessary to keep the lungs clear of mucous. You must adapt to the child's behavior. Concentrating on the child's needs rather than on the behavior may help *you* to change.

Is a Change Justified?

Do you have a good reason for wanting to change the child's behavior? What is your educational reason for wanting to alter the behavior? In other words, make sure the behavior change is good for the child, not just more convenient.

For example, you might have a child who wants to sit on the sidelines for five or ten minutes each day before joining activities. If you have an opening "circle time" to introduce the day's activities, you may want all the children to participate. But the child may truly need the time to adjust to preschool in order to be comfortable. In this case, you may have to make an exception and not try to force the child to participate in the opening circle activity.

Can You Think of Substitute Behavior?

What behavior do you want the child to substitute for unacceptable behavior? One good way to help children change undesirable behavior is to teach them a good substitute.

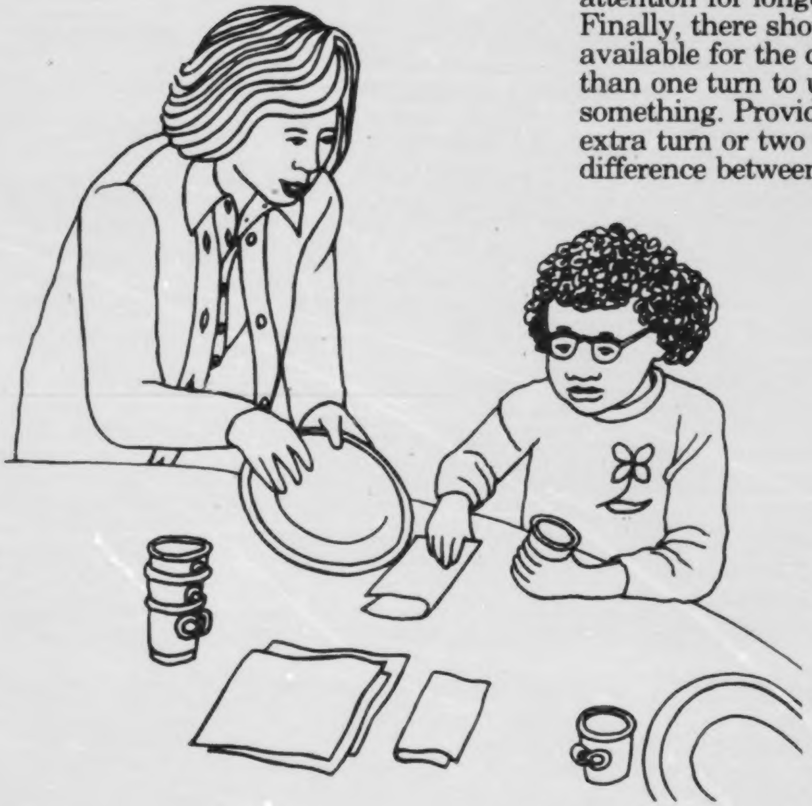
For example, a child who has trouble sitting and waiting for snack to be served can be given a task such as passing out napkins and cups to help occupy him or her until the snack is served. Make sure that the new behavior *competes* with the inappropriate one. Claudia cannot run around and set the snack table at the same time, so giving her this task would be a successful technique for her.

4.

Pacing

Plan your day so that the activities are varied. Alternate between active and quiet activities, between organized activities and free play. When you teach new skills, present them first in familiar contexts, along with some skills the child already has. This lessens the child's uncertainty and frustration.

A child with a health impairment is especially sensitive to the pace of the day. Some health impaired children tire easily, and may need more quiet times than non-handicapped children. This doesn't necessarily mean a nap—often ten minutes alone in the book corner is enough. Also, the child's attention span may need training and strengthening if he or she isn't used to preschool. If a child's attention span is short, make the activities short, too. You can lengthen them as the child learns to pay attention for longer stretches of time. Finally, there should be extra time available for the child who needs more than one turn to understand or to do something. Providing time for that extra turn or two can mean the difference between success and failure.



5.
Grouping

At home children with special needs are sometimes isolated from other children. One of the benefits of mainstreaming is that it offers these children the opportunity to play with other children and to learn a new skill by seeing someone else do it correctly. You can plan and organize your learning situations so that this interaction, called "peer modeling," can occur. In areas where a handicapped child is weak, another child (a peer) who has the skill can act as a model. Likewise, in areas where a handicapped child excels, she or he might be paired with a less skilled child.

No child, handicapped or non-handicapped, is good at everything or bad at everything. All children should have the opportunity to give help to their classmates and receive help from them.

Try very hard not to exclude a child with special needs from any activity, especially large-group activities. Exclusion means isolation, and isolation means feeling different and bad. To include the child, give extra assistance or change the expectations for the child. For example, with an asthmatic child, add a "rest stop" to an obstacle course so that he or she can take a minute to rest on the way.

Individualized teaching does not mean isolating a child. Rather, it involves modifying the activity so that all children can participate in the same learning situation.

6.
Children Helping Children

We have already mentioned the benefit of using children as models for each other. This principle applies directly to having non-handicapped children assist you in mainstreaming children with special needs. Your youngsters will probably be eager to serve as helpers. This experience has a bonus: it helps them to develop positive attitudes about handicapped people. In addition, their assistance will free some of your time for other responsibilities. Ways in which non-handicapped children can help in mainstreaming a handicapped child include:

- **introducing a new child to the physical setting of the classroom**
- **helping a confused child to organize his or her materials for a cutting and pasting activity**
- **providing a child with opportunities to practice a newly learned skill**
- **assisting a poorly coordinated child during playground games**
- **alerting a child whose attention wanders that the teacher is about to give a direction**
- **sitting close to an easily frightened child to provide support when the lights go out during a film-strip.**

Peer helpers *should* be used often. This includes using a handicapped child in areas where he or she excels. In this way, all the children will learn that they each have areas of strength and weakness. They will also learn that the need to receive help does not mean that they are failures, or less worthy than those who offer help.

You may find that there is a non-handicapped child in your class who is unusually responsible and enjoys being a big brother or big sister to a health impaired child. This is fine, but make sure that you are not relying so much on your helper that he or she becomes a substitute teacher, or does more for the child than is needed.

7.

Breaking Down Skills

Every skill is really composed of many sub-skills—there is no such thing as a one-step activity. Skills such as tying shoelaces, cutting a circle with scissors, doing a somersault, or doing a puzzle consist of many sub-skills.

Some children can master a new skill very quickly with little help from you. These children already know the sub-skills and can use them in performing the new skill. Handicapped children, however, don't have some of the sub-skills necessary, and need to be taught them before they can succeed at the overall activity.

For these children, you can break down the activity into sub-skills that can be learned at their current skill level. For example, if you want to teach a child to skip, check to see if he or she can hop on both feet. Hopping is a sub-skill, and must be mastered first.

Feel free to express your affection.

8.

Sequencing Activities

In addition to sequencing skills within an activity, sequence a series of activities. Start with simple activities and gradually increase the level of difficulty as a child learns. Be sure to demonstrate to a child how the skills learned in one activity can be used in others. A health impaired child may need to repeat a sub-skill, a skill, or an activity several times with your help and several more times without it, before moving on to new activities at a more difficult level.

9.

Physical Contact and Guidance

Use physical contact to help a child with special needs: to ensure safety, to provide guidance, and to limit space. Feel free to express your affectionate feelings with a pat or a hug. Guard against using physical contact to punish a child.

With some health impairments, physical contact can be part of a treatment plan. For instance, some children with asthma are helped to stay calm during an attack if you place a hand on their shoulder. *Following* any kind of severe attack (grand mal seizure, coughing, or wheezing) a child may want to be held for reassurance.

10.

Avoiding Over-Dependence

It is sometimes hard to be accurate and realistic about what children are capable of doing for themselves. In the case of many handicapped children, it is all too easy to assume that they are more helpless than they really are. Seeing that they cannot do some things may make us think that they cannot do others.

Furthermore, some parents may have overprotected their handicapped child to make up for all the extra problems their child has to deal with. This means that some children may come to Head Start expecting that everything will be done for them, simply because this is what they are used to.

Overprotecting a child is a trap you don't have to get caught in. You have to ask yourself: "Is this really impossible for this child? Could the child do it alone with more time? Could the child do it with some help from me?" Think hard, and be honest. It is tempting to do things for any child, because you can do them faster and better. But if you're always the one who zips the zipper, sets out the paint brushes, and puts the puzzle together, the child won't have a chance to learn to do these things.

The extra patience and encouragement you give to children who try to do things on their own will pay off many times in the future. You can help children think of themselves as able, not unable. As they grow up, they will be in the habit of expecting as much from themselves as they are really capable of.

11. Confidentiality

Making sure that confidential information stays confidential involves careful record keeping and watching what you say.

Project Head Start requires programs to institute careful procedures, "including confidentiality of program records, to insure that no individual child or family is mislabeled or stigmatized with reference to a handicapping condition" (OCD Transmittal Notice N-30-333-1-30, "Head Start Services to Handicapped Children," February 28, 1973, page 6). The Head Start Performance Standards also spell out procedures to guarantee confidentiality of records:

- **Records must be stored in a locked place where unauthorized people can't see them.**
- **The Head Start director must determine which staff members can see which parts of the records and for which reasons.**
- **Parents must fill out written consent forms to give anyone outside of Head Start permission to see the records.**

These procedures are designed to make sure that all records on a handicapped child and his or her family are seen only by people who need to see them for legitimate educational or medical reasons.

Avoid copying down confidential information from the child's records. Limit the confidential information you do write down to what you need for working with the child.

You should not repeat confidential information about handicapped children or their parents, either to other parents or to staff members who are not working with the children. This is an invasion of the privacy to which handicapped children and their parents have a right.

If you need to share confidential information with another staff member to help him or her work better with the child, have your discussion in a private place and limit it to necessary information only.

Teachers have sometimes been embarrassed to find that their comments about a handicapped child's family have been repeated to the family. Parents of children with special needs can be sensitive about this issue, and understandably so. Be discreet about what you say—and to whom you say it.

Activities

Many of the activities that you do each day in your classroom are good for children with health impairments. Children with health problems vary just as much as all human beings do. Some get along very well in most activities. Others need special planning to modify activities so that they can participate. Like all preschoolers, they need to learn skills in the following areas:

- **gross motor**
- **fine motor**
- **language and speech**
- **self-help**
- **social**
- **cognitive**

Most preschool activities serve as learning experiences for more than one of these skills, and there are no particular activities that are best suited for all health impaired children. The conditions that are considered health impairments and the severity of those conditions vary greatly, and you will have to consider each child individually. However, as you develop activities that include health impaired children, here are some things to keep in mind.

Health impaired children may need to "do it themselves" even more than the other children in your program. If children have not had the chance to do things for themselves before, they may ask for more help than they really need. It is better for Lorraine to go home with a messy project that *she* did, than a beautiful one that was really done by the teacher. Gaining competency in the six developmental areas is a major factor in a child's developing a positive self-concept.

A health impaired child is more likely to need rest throughout the day. This means you should pay special attention to the pacing of activities, and that you should alternate between busy and quiet activities. But just because a health impaired child may have less stamina and need more rest than the other children in your program, this does not mean that he or she should be restricted from activities. Do not restrict a child from *any activity* unless there is a clear physical or emotional danger. Encourage the child wherever possible. Children, like adults, thrive on support and encouragement. Give them a chance to *feel accomplishment,* no matter how small the event might be.

To reassure yourself about a child's ability to participate, you could make up a list of the activities that you do in your program and discuss it with the child's doctor or nurse. Ask them to check off anything that the child should not do, and to describe modifications or alternatives so that the child can participate.

Since many health impaired children have been hospitalized, it is fairly common for them to have greater than usual childhood fears and concerns about doctors, hospitals, and separation from parents. Often what has frightened them most is the unpredictability of the hospital experience and the loss of control that they felt there. Establishing a routine in the classroom can help these children feel more secure, because it helps them anticipate and predict their environment. Of course, routine helps any child feel more comfortable in the classroom, but it may be especially necessary for helping health impaired children develop a sense of trust.

If a child has been through lengthy confinement at home or in the hospital, he or she will have had little opportunity to learn to play with other children. Such a child also needs help learning how to cooperate with other children: how to share, how to take turns, and how to play in a group of children—not just alone.

This section describes activities that can help children improve their performance in all areas of development. As you know, any activity can be used to teach many kinds of skills. Depending on how the activity is done, some skills get more practice than others. For example, if you wish to use a movement activity to practice gross motor coordination, many movement activities are suitable. But if you want to provide practice in the cognitive skill of sequencing, you will need a movement activity that calls for a particular order (for example, "Head, Shoulders, Knees, and Toes"). You can use the activities in this section to provide practice in many other skills besides the ones we have listed.

Story Reading

Reading stories to children can help them improve their:

- **ability to pay attention**
- **listening skills**
- **vocabulary development (naming pictures)**
- **language development (understanding spoken words)**
- **memory (retelling the story)**
- **ability to socialize with classmates.**

Preparation

Plan ahead of time which book to read. Try to find one that ties in with something else the children have been doing or are going to do that day. For example, if someone is bringing a pet turtle to class, you may want to read Dr. Seuss's **Yertle the Turtle.** Big, bright, colorful pictures, pop-up illustrations, and touchable books help the children stay interested and tuned in.

It's important to read the book carefully ahead of time, so you will know whether there are parts of it that might upset any of your children. Without giving a new story away, prepare the children for it by telling them a little bit about it and about what to watch for. Know the words and pictures well enough so that you can adapt a story to make it move faster, to explain new words and concepts, and to keep most of your attention on the children.

Conducting the Activity

1. Prepare the children for a quiet activity by talking softly, having them think quiet thoughts, or using other relaxing methods.
2. Let the children get comfortable on mats, pillows, or rugs, in a place where each can see the book and pictures. Make sure, though, that they aren't so crowded together that they "bother" each other without meaning to.
3. Before you begin to read, tell the children a little about the story and what to watch and listen for.
4. Read the story using different voices for different characters. Vary the loudness and softness of your voice. Change the speed a little, but don't read so fast that children can't follow.
5. Show the pictures as you go along, giving children time to look at, touch, and feel the illustrations.
6. Encourage the children to comment on the story, and to retell parts of it.
7. Tie the story back to the classroom activities: "We have a turtle, too."

Tips

People listen in all kinds of positions. It's okay if the child wants to lean on you, lie down, or listen from under the table.

If the child wanders away, don't make a big deal about it. You may want to draw the child back by asking him or her to point to something. Or you can have the child help you turn pages. Or you can wait until the next story.

Use short stories. Children especially like rhyming words and nonsense sounds in rhythm.

Children who have been through frightening experiences (such as prolonged hospitalization or a death in the family) can get some distance from them through storytelling. At the same time it allows them to express feelings they have about these past experiences. There are various children's books on hospitalization, though most of them describe more positive situations than what a health impaired child will have experienced.

If you suspect that a story will alarm or upset a child, try reading it to the child ahead of time. Offer him or her an opportunity to ask questions.

Many teachers find it helpful to make up a story for a child who has a particular worry. Often it helps to change the sex or age of the story character, so that the situation described is not too close to the child. Having made up a story, don't be surprised to hear the child ask over and over, "Tell me the story of the girl who went to the hospital," or, "Tell about when it got dark." Such a story is worth writing down for the child to keep.

Show the pictures as you go along.

Arrivals, Departures, and Transitions

These events in the day can be just as important as any activity. They can help children develop:

- **a trusting relationship with adult(s)**
- **independence**
- **ability to accept separation**
- **concept of time**
- **independence in removing and putting on outerwear.**

Preparation

Arrivals, departures, and transitions can be difficult times for all children, but they are especially so for children who are health impaired. These times involve separation or reunion with important persons, or the need to end one activity and begin a new one. Many children feel especially uncertain at these times about who will care for them.

Children who have had frequent or prolonged hospitalizations may have special difficulties. They may feel helpless and abandoned. They may feel that adults are going to "hurt" them. Such children may become very dependent on you during transitions. They may cry, whine, or cling to you. On the other hand, a child who has experienced pain during medical treatment by doctors or nurses may be fearful of contact with adults. This child may shy away from close contact with you. In either case, it is important to provide a predictable routine to help make the children feel more secure.

Conducting the Activity

1. During arrival time, have an "official greeter" at the door. This should be the same person each day. The greeter can meet the children at the door, help with outerwear, and spend a few minutes chatting at the start of the day. This little ceremony, practiced by reliable persons, says to the child, "Hello, I'm glad you're here. Things are just the same as when you left. You can count on us."
2. Upon departure, have the same person send the children off. While helping the children put on their coats and hats, this person could describe the plans for the next day.

Tips

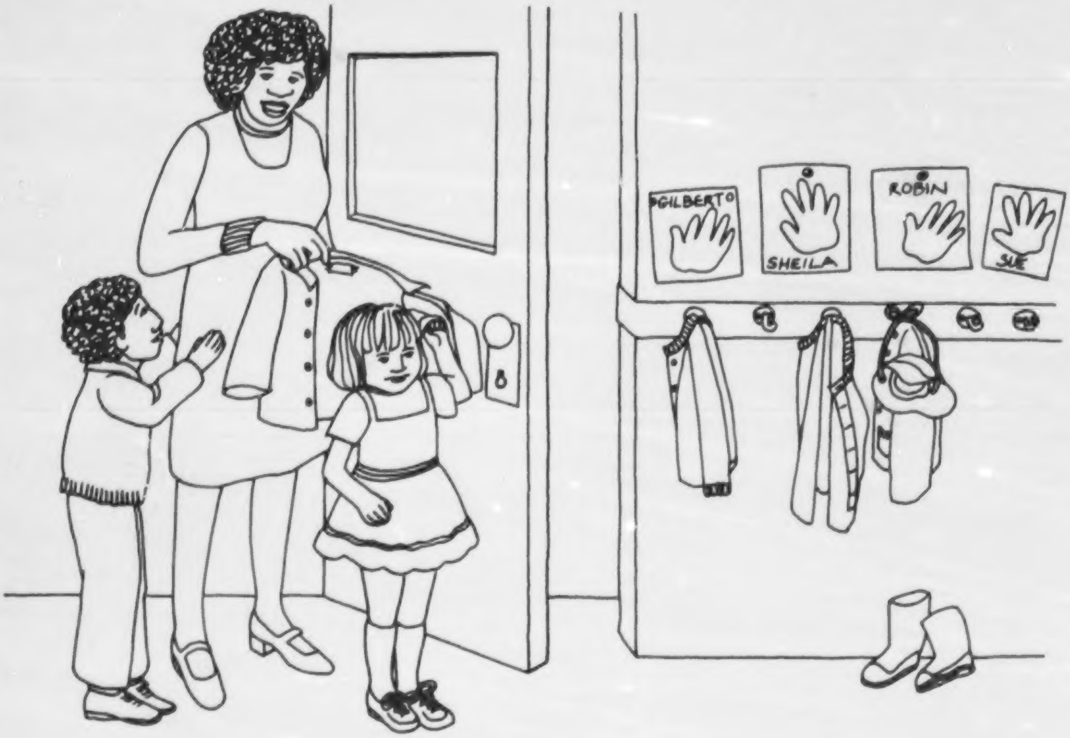
Some children like to "sit and watch" for a while. Do not force a child to participate in the group immediately upon arrival. You can help children overcome their initial fears and hesitation by immediately giving them some small responsibility to make them feel at home.

Help to establish a routine by marking coat hooks with each child's name. Letting children hang their coats on their own hooks each day tells them that they have a place in the classroom.

Warn children before transitions take place. "In five minutes, we will begin to clean up for snack."

Before departure time, make sure the child who has difficulty with transitions has had some pleasant and successful experience. Matter-of-factly praise the child for it while helping with the coats, and say you will see him or her the next day.

Use common sense: provide lots of tender loving care for the child who is frightened, but watch for your chance to allow him or her to let go and function independently.



Housekeeping, Dress-Up, and Make Believe

These types of activities help children:

- **learn to cooperate**
- **learn to share**
- **build role playing skills**
- **relieve their fears**
- **practice their dressing skills.**

Preparation

Your classroom probably has a housekeeping or doll corner. You may also have a make-believe corner, with puppets, a doll house, and small dolls. In addition, you may want to consider having a dress-up area, with many old clothes for the children to try on. Include items with various kinds of fasteners (hooks and eyes, buttons, zippers). You might even want to have a "hospital corner" with a cot, medical implements, hospital "johnnies," and nurse and doctor uniforms.

Encourage children to act out their own stories and feelings with these materials.

Conducting the Activity

1. Be nearby in case a child needs help or encouragement. Children may use this area as a place to discuss their health impairments. Be prepared to offer simple explanations to them and other children when needed.

2. Establish "rules of the house." For example, "No more than four people can be in the hospital corner at one time."

Tips

All children should get to play each role. For instance, if you notice that the girls always play the nurse or mother, or that a health impaired child always plays the baby or patient, suggest that they play different roles next time. It may be particularly useful to a health impaired child to feel that he or she is "in charge" as, for example, being the doctor in the hospital corner.

Games, Puzzles, and Manipulative Activities

These types of activities can help children improve their:

- **eye/hand coordination**
- **perceptual development (size, shape, form, direction)**
- **task organization and sequencing**
- **decision making.**

Preparation

These activities are generally done independently by a child or by a small group of children. But some special preparation is helpful. Materials should be carefully boxed or arranged in clearly marked areas on low shelves. You could have one shelf area for "hard" games that need a teacher's help, and another for "easy" things to do alone. You might have a special shelf where new things are put when they are first introduced to the class. Make these differences clear so that children can develop independence in their choices: label the shelves with pictures or diagrams as well as printed signs. Remove things from the shelves ahead of time if they are too difficult for a child who will be in that area, or on a day when you do not have enough help to supervise children properly.

Conducting the Activity

If you have organized and labeled the materials, the children should not need much supervision. It should be enough to be aware of what children are doing and to help if someone is having trouble.

Tips

Take time to observe which activities a child prefers, his or her style in approaching activities, and his or her problem areas. Modify favorite activities as needed to focus on a particular skill.

If there are things that can be especially helpful in developing particular skills for a child, put them in a separate cardboard box labeled with the child's name. Then remind the child when it is time for that activity, and help him or her get started.

By suggesting two to three activities that provide practice in a particular skill, you give a child a choice. In this way the child has the chance to practice decision making.

Use a variety of teaching techniques. For example, demonstrate exactly the motions to go through in using a toy, verbally describe the steps, and move the child's hands through the activity.

If a child is reluctant to leave an activity that he or she has mastered, you will need to encourage the child to do so. Demonstrate new or unfamiliar activities, lending guidance and reassurance as necessary. Help the child find a balance between active and quiet as well as group and independent activities.

Playground

Playground activities help children improve their:

- **sense of balance**
- **rhythm**
- **body awareness**
- **muscle strength**
- **ability to follow directions.**

Preparation

See that the play area is safe. The area should be fenced in, free of broken glass, and small enough to be well supervised. If the area has equipment in it that is designed for older children (such as high jungle gyms with widely spaced bars), it might present dangers to your children, especially children with epilepsy or hemophilia. You might simply make that equipment off-limits to everyone. Otherwise, you could place mats underneath to cushion any falls, or have an adult immediately nearby to prevent falls.

Playground or gym time should be a planned part of every day. This is particularly necessary for a child with limited gross motor experience. Any equipment (balls, hoops, beanbags) you wish to use should be ready and in good shape. Playground time should include free play as well as planned games and activities. Cooperative play should be encouraged.

Conducting the Activity

1. Begin with planned activities.
2. Give verbal directions and show the children what to do.
3. Some health impaired children may need to watch you and to follow a familiar routine as the group moves from indoors to outdoors. Make the transition predictable by telling the children what will happen: "First we're going to put on our coats. Then we will go outside to the play shed to get out the swings. Everyone will have a chance to play on the swings. When we are done everyone should bring one thing back to the shed." Remind children of each item in this series of events as it occurs. "Everyone get on your coats now. That's what we do first before going outside." This kind of predictability provides security and structure for all the children.
4. Not all children feel comfortable running and playing at a distance from adults, or in a large outdoor space. You may want to provide something familiar from indoors, such as a coloring book or a favorite doll. Or you might set up a lookout post for a child who wants to watch before joining the group.
5. Plan a variety of activities to do outdoors: active, slow, noisy, and quiet.
6. Always let the children know where you are. If you leave the playground, tell the children where you are going and when you will be back. Never leave children without supervision.

Tips

To insure success for all children, begin with simple activities such as rolling, crawling, animal walks, and balancing. Devise games around these kinds of activities.

Increase the difficulty of the activities as the children's skills improve. For instance, begin by rolling large balls on the floor, then move on to rolling smaller balls. Or begin with rolling and/or crawling on an open floor and gradually add objects to go over, under, and through, making a progressively more difficult obstacle course.

Give children with health impairments time to practice new activities away from the group, or after everyone else has left the playground. Given an opportunity to perfect new skills and to gain confidence, these children can enter the group as "old hands."

Avoid crowding the children together while putting on their coats or waiting at the door leading to the playground. *Transitions are difficult for all children, so plan these times carefully.*

Don't have children choose sides in games. Count off or divide children in other ways, so that no child feels left out.

End every activity in a way that makes starting the next one easier. For example, end a race by having each child sit down at the end of his or her turn.

Be a part of the group by demonstrating new activities. Give one-step directions until children are familiar with them.

Nature or Science Corner

Playing in a nature or science corner can give children:

- **experience with other living things**
- **knowledge of the environment.**

Preparation

If you have an asthmatic child in your class, you need to take special care in choosing animals and materials for a nature or science corner. Fur-bearing and feathered animals are often problems for asthmatic children. The same is true of ragweed and other pollen bearing plants. (In general, avoid plants that may be poisonous.) Label all flower pots and animal cages with a picture label. Allow the children the responsibility of helping to care for the animals and plants.

Growing plants provide many opportunities for learning.

Conducting the Activity

1. If allergies are a problem in your classroom, avoid furry or feathered animals. Choose animals such as lizards, fish, turtles, and snakes—rather than gerbils, hamsters, and parakeets.
2. Include children in the care of the animals, but be sure an adult supervises them. Make sure that no animal is abused or overfed.
3. Plants can enrich a classroom because there are many activities involved in their growth. An activity that calls for sprouting beans, watching them grow, taking turns rinsing them, and then watching the teacher cook them so the children can taste them can be very rewarding.

Tips

You might consider bringing in other animals for short-term visits, to add variety without long-term responsibility. Libraries and science museums will sometimes loan out unusual animals, or perhaps children could bring in a pet from home for a day.

Some children may be afraid of certain animals. Find out from the parents what fears the child may have, and work together to help the child overcome the fears.

Music

Music activities can help children improve their:

- **listening skills**
- **ability to pay attention**
- **sense of rhythm, sequencing**
- **fine motor skills (manipulating musical instruments)**
- **speech development**
- **ability to socialize with classmates**
- **body movement and awareness.**

Preparation

Plan music activities so that they relate to other classroom activities. If you are doing a unit on animals, community helpers, or body parts, find songs to play and sing that relate to these topics. Have all the equipment that you will use (record player, rhythm instruments, records) ready and working. Plan ways for all children to be successful in the activity. For example, some may clap along, others beat a drum, and others dance to the music.

Conducting the Activity

1. Tell the children what the activity is. Show them how to do it.
2. Allow some time for the children to do what they would like to do with the music: dance, clap, sing.
3. Relate the music to the other classroom activities.

Tips

Use music for exercise, self-expression, and keeping time, not just for singing.

Use different kinds of music to calm down or pep up the children, or as a gentle way to signal a change in activities. Music can help some health impaired children avoid a crisis, or calm everyone down if a crisis has occurred.

Body image songs and games make excellent music activities. These include singing games such as "Where is Thumbkin?" "Looby Loo" ("You put your right hand in, you put your right hand out…"), "Jim Along Josie" ("Slide along, Jim says"). These are activities in which words have to match actions. Children have to remain alert to hear when to change the action.

Use music for self-expression and keeping time.

Snack

Snack time can be an opportunity for children to improve their ability to:

- **eat independently**
- **socialize with classmates**
- **talk (asking for what they want, naming foods)**
- **grasp and coordinate eye-hand movement**
- **understand concepts (number of crackers, size of cup).**

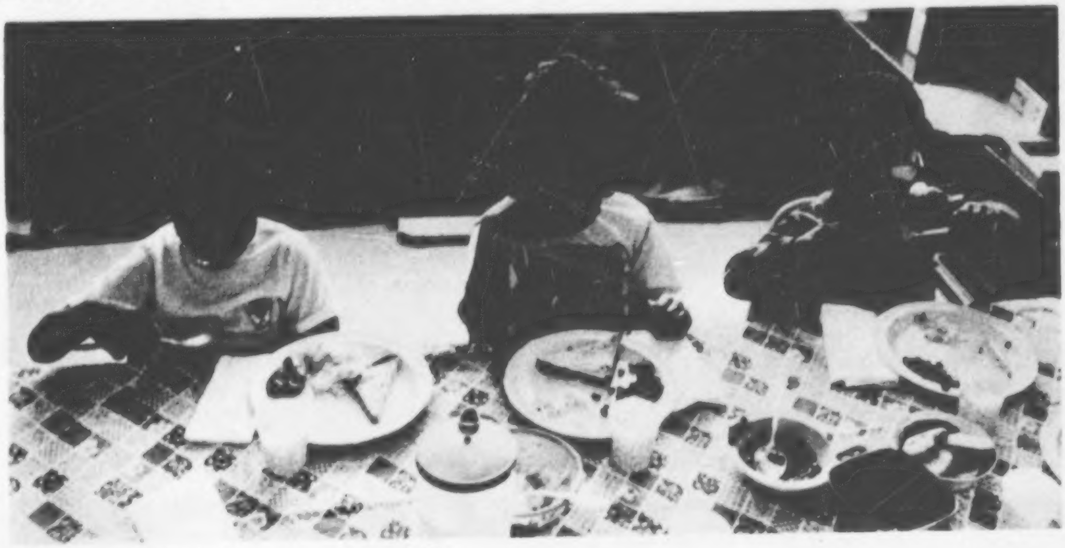
Preparation

Ask parents in advance about the food preferences and eating habits of their children. Find out if there are any dietary restrictions or supplements for a health impaired child. If so, plan the snack with the program's cook or dietician. Change the snack for all children, so that the child with the food restriction is not singled out.

For example, children with diabetes must limit their sugar intake, and children with cystic fibrosis must limit their fat intake. Supplements would include the enzyme tablets and salt needed by a child with cystic fibrosis.

Conducting the Activity

1. Encourage children to help with snack time—setting tables, passing food, pouring juice, cleanup.
2. Establish a regular routine for getting to the table, passing food, and indicating how much each child is expected to take. Make these routines "rules of the house" that are public and impersonal. If there is something that is hard to portion out (e.g., raisins or peanuts), divide them ahead of time and give each child a small paper cup full.
3. Use snack time as a social time to share, talk, and take turns.
4. Use snack time as a self-feeding teaching time for children who are just learning to eat independently. Encourage independence in all activities, such as opening one's own milk carton or wiping up one's own spills.
5. Use a routine for cleanup.



Encourage independence in eating skills.

Tips

Some health impaired children are fussy about food. Some may be reluctant to chew and swallow any solid foods. Introduce new foods gradually and in small amounts. Be liberal with praise when a child is willing to taste an unfamiliar food.

Children and adults may be shocked by the amount of salt that the child with cystic fibrosis uses. Explain matter-of-factly that the child's body needs more salt and that this is okay for that particular child. You and the child may be more comfortable if enzyme tablets are taken in private. Again, treat this matter-of-factly.

Occasionally you may have a situation in which a child with a health impairment can't participate (for instance, when a mother brings birthday cupcakes or Valentine cookies, which may be off-limits for the diabetic child). Tell the child you know how hard it is at times to pass up these treats. Compliment the child for not complaining. Perhaps you can keep a special treat on hand for such occasions. The child's parents can help you decide on a special treat that falls within the child's dietary limitations.

Some children have special worries about routines like snack. You can ease their anxiety by sticking close to fixed procedure. Provide food when you say you will, remain seated if you promised that you would, and see that each child is treated fairly.

Set rules about "seconds" ahead of time. If a child is constantly worried about whether there will be enough food to go around, it may be helpful to allow him or her to sit near you or the person in charge of, for example, the juice pitcher.

Rest

As we all know, rest is also an important "activity." It is especially important for young children. Some health impaired children need more rest than non-handicapped children. Rest gives them and other youngsters a chance to relax and be calm, even if they don't fall asleep.

Preparation

Make rest a regular part of the day that children can anticipate. Have a cot or mat ready for each child, and a routine for getting them out and putting them away. Find out about each child's home routine. For instance, does the child like to be covered, need a special toy, require a long or short nap? Some health impaired children must lie in certain positions or need propping up. Find out about any such requirements.

Conducting the Activity

1. Have children get out the rugs, mats, or cots following the established routine.
2. Help the children relax with soft music, dim lights, or a quiet story.
3. Find a gentle way to end the rest period and put away the rugs, cots, and mats.

Tips

Don't expect all children to sleep. Allow for quiet movement and quiet activity.

Don't expect children to rest right after a noisy activity. Help to quiet and relax them *before* rest time. Everyone needs some "calming down" time.

Trips

Taking trips can help children:

- **learn to trust that a change in routine won't lead to disaster or be frightening**
- **learn to adapt to the unknown and unexpected**
- **develop understanding through firsthand experience**
- **expand vocabulary through firsthand experience.**

Preparation

Before any field trip, plan how to provide the extra supervision the children will need.

Review the activity in advance, and try to identify potential trouble spots (such as riding elevators or escalators). Prepare your class for the trip by telling a story about where you are going, showing pictures, and reviewing, step-by-step, what will happen, who will be there, and how and when you will leave and return to the program.

Conducting the Activity

1. Make the transition from the classroom to the special activity as smoothly as possible. Allow plenty of time to get everyone ready, so that no one feels rushed.
2. Put a name tag on each child, and make sure that everyone has a "buddy" or partner to hold hands with.
3. Try to avoid confusion, rushing, and standing in a line or in a crowd for a long time.
4. When you return, review the trip with the children—where you went and what you saw.

Tips

Choose nearby places for trips. Go to places that the children may see often, like the neighborhood store or "the big kids'" school. Help them understand what happens there. Some more elaborate trips (circus, basketball game, zoo) can be very exciting for the children, but think about the meaningfulness of the trip from the child's point of view. You may also want to consider a trip to a hospital, clinic or doctor's office, so that a health impaired child can visit them without being a patient.

Plan to have extra adults accompany you on a field trip. These can be parents or other volunteers. Consider asking the parents of a health impaired child to help, but do not make them feel they must come on every trip.

Be sure that the children use the bathroom before you leave. If the trip will be long, think about the availability of rest rooms and the advisability of taking along a snack such as apple slices or raisins.

See that the field trip does not interfere with a child's medical regimen. Consider whether the trip will interfere with a child's diet, exceed the child's energy level, or bring the child into contact with allergens (substances to which the child is allergic). Will you need to bring along any medications?

Establish a "buddy system" so that each child has a friend to watch out for and to make him or her feel safe. Use name tags, including the program name and phone number.

Chapter 5:

Parents and Teachers as Partners

5

Parent involvement is the cornerstone of a successful Head Start program.

One of Head Start's unique achievements has been the involvement of parents in the education of their children. Parents are the primary educators of their children, and their involvement is the cornerstone of a successful Head Start program. This partnership is even more important in the education of a child who is handicapped, for the following reasons:

- ***Parents know their children's strengths and limitations better than anyone else. They can help a teacher understand and plan for their child.***
- ***A joint family/teacher effort is essential for developing the best program for a child and for ensuring that the child will benefit as much as possible from the Head Start experience.***
- ***Head Start may be the first preschool experience the child and parents will participate in. Making it a successful experience will have positive effects on the child's school years to come.***
- ***Children with moderate or severe health impairments are often following treatment plans involving such things as medication, diet, and exercise. Normally it is the responsibility of the parents to carry out the treatment plan. It will be important for you to know, however, what the treatment plan involves.***

Parents as Decision-Makers

Head Start has always considered parents important decision-makers for their child, because they are the main influence on the child's development. They need to reinforce what you are teaching in preschool if maximum progress is to be made. Changes in a child that come about through your efforts, the efforts of specialists who provide services, and the experience of mainstreaming affect parents. For all these reasons, it is important that the parents participate directly in what you are trying to accomplish with the child in the program.

Direct parent involvement in decisions affecting their child is essential. They should decide with you what and how you teach their child, and what efforts they will make at home. They should participate in decisions involving formal assessment and diagnosis of their child, and selection and arrangements for any special services that are needed. They should be a part of any decisions that are made as a result of assessments of their child's progress.

One of the major areas in which parents are needed as decision-makers is in the development of an individualized education plan for their child. This plan is a written statement developed in meetings of the diagnostic team, the parents, and the teacher. It spells out the educational goals for the child, the activities that will take place in the classroom, the involvement of parents, the special services that will be provided by other agencies, and details of the evaluation procedure. Parental consent is required by law at two points: to give permission for the diagnostic process to take place, and to give permission to put into effect the individualized education plan that has been developed for the child. This requirement is intended to guarantee that parents have their rightful say in the education of their child.

The rest of this chapter discusses specific ways in which parents can help in the education of their child, and provides guidelines for teachers in working with the parents of handicapped children.

What Parents Can Do

Helping Your Child

As parents, you are the first and most important educators of your child. You can help in your child's education in a number of ways, both at home and in the classroom. You might begin by taking the following steps:

1. Get to know your child's teacher. Give him or her a realistic idea of how much you can do. Take into consideration the amount of extra time you can afford to spend working with your child, as well as how much time you would like to spend. Even if you have a fair amount of free time available, you may find it difficult to work closely with your child for long periods of time.

2. Recognize that you have a tremendous influence on the growth and development of your child. What you do *does* make an enormous difference. Try to participate in your child's learning as much as possible.

3. Seek guidance from your child's teacher if you are not certain how to use everyday events at home as learning experiences for your child. The teacher may be able to suggest specific activities you can do to help him or her build necessary skills.

4. Build on Head Start's firm commitment to partnership with parents. You aren't alone in your efforts to help your child. You now have partners who can help promote the well-being and development of your child: the teacher, other staff members in the program, and agencies and public school resources in the community.

The next section discusses how to prepare your child for the Head Start program, some things you may find helpful to discuss with the child's teacher, and how to use everyday events in the home to foster your child's development.

Preparing Your Child

You can help both your child and the program staff by preparing the child for the Head Start program. Just before the start of class, bring your child to the Head Start center. Introduce yourself and your child to the teacher and other staff members. Encourage your child to explore the classroom and to play with some of the materials. Try to make sure that your child has a good time during this visit.

Some handicapped children may be frightened at first about leaving home. You and the teacher may want to discuss whether it would be helpful to your child if you remain in the classroom during the first few days. At some point your child will have to feel comfortable in the classroom without your being there. This takes more time for some children than for others.

A little bit of home at preschool and a little bit of preschool at home go a long way toward helping children feel comfortable and secure. Perhaps at home you can hang some pictures of the classroom or the teacher. Or your youngster could be sent to class with a favorite toy or familiar object from home, to increase his or her feelings of security.

Try to have your child arrive in class on time. Let the teacher know of important events at home that might influence the child's behavior in class. These special events may be happy times (such as birthdays, a family visitor, or a trip), or unhappy times (such as death, illness, or disruption in the family routine).

Understanding Skill Areas

You may feel that you need help from the teacher in understanding the skill areas—such as language skills, motor skills, and social skills—that your child has serious weaknesses in. Don't hesitate to approach the teacher for this help, or for help in figuring out ways to use daily home activities to help build on the child's strengths and work on the child's problems.

Try to talk frequently with the teacher in terms of specific skills. Exchange suggestions. If your child is living with both parents, both of you should try to get involved in conferences and conversations. Each parent may have a different perspective.

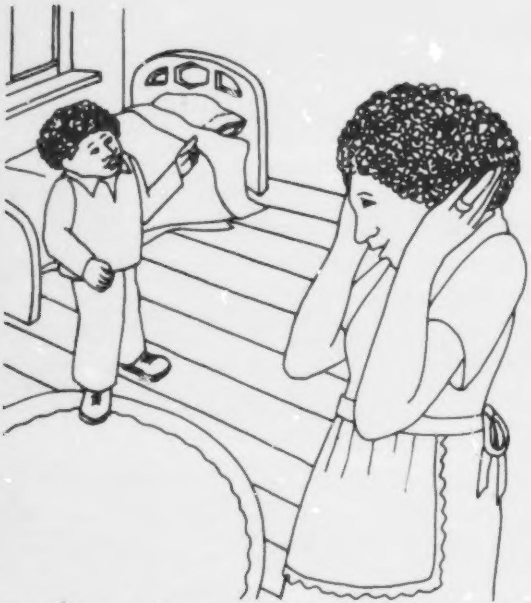
Ask to see for yourself what the teacher does and how he or she does it in the classroom. You might even want to try practicing skills with your child in the classroom. Sometimes it is better for you to work with a child other than your own. But in either case it will give you practice and an opportunity to exchange ideas with the teacher.

Describe to the teacher an average day at home, in order to learn how you can use these everyday events to work on the skills your child is having problems with.

Additional Effort

All young children learn by having different experiences and by trying things out. This means that your child needs to be involved as much as possible in daily activities at home, just like other children. If it's good for a non-handicapped child to help feed the dog, then it's good for a health impaired child. Any activity the child can be involved in can go a long way toward helping him or her build self-confidence and competence.

You will probably have to make some additional effort to help your child become actively involved in daily events. Work out with the teacher what you can realistically do, but recognize that extra effort is necessary.



"Oh, Danny, how nice your bed looks!"

Home Activities

Activities at home should be as enjoyable as possible for the child and for the family. Don't overburden yourself or your child. Ask the teacher to suggest things that can *easily* be built into the daily routine. If the suggestions are very hard to carry out, they may not get done.

On the other hand, if you are willing to take a more active teaching role at home, ask for extra suggestions for things you can do. Talk with the teacher about what you like to do with your child and about what the child likes to do at home. Those activities can all be learning opportunities.

If you would like some specific activities to do at home with your child, look over the activities in Chapter 4. Remember, however, that you need not be a formal teacher for your child. Often the best way to help your child is to be loving and helpful, and to use the daily routine as a way to teach the child. All of the things that you do at home can be used to help the child with special needs learn more about the world. As you work with your child, keep the following tips in mind.

1. Fostering Independence

Help your child become as independent as possible. It's tempting for all of us to do things for children that they could do on their own, since we can do them faster and better. But it is very important for handicapped children to learn to do as much as they can by themselves. Independence helps children feel good about themselves and improves their ability to get along with others.

2. Praise and Encouragement

We all benefit from honest praise—children as well as adults. Praise program staff honestly for their efforts with your child, and ask them for feedback on your work with the child. Remember also to praise your child's achievements. For some children, even small tasks can take a lot of time to master. Every achievement—from learning to sit still to managing to eat independently—represents real progress and deserves real praise.

Also, praise the child for trying, even if failure or mistakes result. Continued effort is essential for children with special needs, who have many obstacles to overcome. Repeated, steady praise will help a child to keep on trying.

It is important, however, that your praise be honest, and that your child has done something to earn it. Children are very good at recognizing insincerity. If you praise your child at times when he or she has not been trying or has not mastered something, the youngster will be confused and will not understand what your expectations are.

Ask the teacher to share assessment results with you. Everyone involved should understand how the child is functioning and share pleasure at the child's progress.

What Teachers Can Do

Guidelines for a Partnership with Parents

Parents of children with special needs are as concerned about their children, or more so, as any other parents. You may want to keep in mind the suggestions below as you work with parents.

1. Establish and Maintain Contact

Describe the Head Start program in detail, and invite the parents to observe and participate in the classroom. Work out the child's educational goals in conference with them. Review the child's short- and long-term objectives with them at least every three months, or whenever needed.

Although at least two home visits a year are required in Head Start programs for all children, you may need to make more visits if a child is handicapped. Maintain contact with the parents as often as you can. Visits, phone calls, notes, and sending children's projects home with them can help parents see the skills their child is learning. As with any child, don't contact parents only when there is a problem. Ask yourself, as often as you have time, "What did the child do today or this week that shows some progress or enjoyment? How can I find time to tell the parent, along with everything else I have to do?"

Some teachers and parents send a notebook back and forth each day or so. Teachers write a short note and send it home. Parents write one back for the child to take to preschool the next day.

2. Know the Family's Limits

Everyone has a personal limit on how much he or she can do for a child at home or in the classroom. Get to know families well enough to understand these limits. Make sure that the suggestions you give them for working with their child can easily be included in their daily routine. For example, ask parents to talk to their child as they help him or her dress, to name the foods the child is eating, and to give the child simple things to do (like putting a spoon by each plate). Encourage parents to visit and participate in your classroom as much as they can.

Some teachers and parents send a notebook back and forth every day or so.

3. Focus on the Child's Education

Families of handicapped children may have various feelings about having a handicapped child. Some may feel angry, some guilty, and some embarrassed. Some may feel that they have a special responsibility to protect their child from all problems and frustrations, and they may expect much less from the child than he or she is really capable of. They may need the help of a psychologist, a social worker, or a counselor in learning to accept and deal with these feelings.

While you can be supportive and sympathetic, you haven't been trained to be a social worker and should not try to take that role. Suggest to these parents that they talk to people who can help them work through their feelings, if you feel they need it. Your main role is to be the teacher of the child. You should concentrate on the child's education and development.

4. Recognize and Deal with Your Feelings

Be aware and honest with yourself about your own feelings toward a handicapped child and his or her family. Negative feelings, such as blame, anger, sorrow, nervousness, and fear, are understandable. Getting to know the child and the family helps to reduce some of these negative feelings.

Think positively about children with special needs. Focus on what they can do, not on what they can't do. Help the parents see their child as someone who can grow, learn, and improve, no matter how severely handicapped. Most of us feel better about ourselves when people look at our strengths rather than our weaknesses.

5. Be Reassuring, but Be Honest

Parents may be worried and upset when their child is about to be evaluated for the first time, or re-evaluated. At such a time, it might be tempting for you to tell them not to worry, and to tell them that everything will be fine. It is natural for you to want to soothe their anxiety. However, you shouldn't tell them these things because in fact you don't know if things really *will* be fine. A false sense of confidence can be hurtful. Be reassuring, be calm, be understanding—but be truthful.

Parents may ask you questions about the child's problems that you can't answer: "What's wrong with my child?" "Will my child learn to talk or move or act like other children by the end of the year?" Don't be afraid to say that you don't know the answers, but help parents find someone with whom they can discuss their concerns. Your social services personnel should be able to help you find people who can answer some questions. The answers to other questions, such as "What will my child be able to do when he grows up?" are often uncertain and complicated. Beware of people who have easy answers.

Some parents need reassurance and evidence that they can help their child. Help them see the many things that they already do that help their children, and tell them about all the things they are doing well.

Concerns of Parents

Parents of Children with Special Needs

Parents of handicapped youngsters often have special concerns. In general, it is wise for you to wait until they bring up these problems, rather than to suggest what the problems might be. Otherwise, you could be creating a problem that they have never felt.

Reading about some of the concerns that parents of children with handicaps often have should help you understand what some parents mean when they hint at a concern without actually saying it.

Enrollment in a Mainstream Classroom

Parents may worry that their child will not fit into the Head Start program. You may need to reassure the family that you want the child in your classroom, and that you believe the child will enjoy and learn from your classroom. Invite the parents to watch and listen to what is going on—let them see for themselves how their child plays with and works with the other children and with you. Seeing is believing.

Acceptance by Other Children

Parents are sometimes concerned that their child will not be liked and accepted, and that other children may be cruel and tease their child.

You can reassure them that preschool-aged children usually do not respond in an unfriendly or negative way to a handicapped child. You can also tell them that you do not allow teasing or bullying of *any* child in your classroom, and that you will deal with it firmly if it should happen.

Of course, some children just don't get along well with others, but this is not a problem that is limited to children with special needs. It is not a reason for a child to avoid the rest of the world. You can tell parents that managing these situations, when and if they arise, is a normal part of your job.

"Seeing is believing" fits here, too, so invite the parents to visit the classroom so that they can get a feeling for the atmosphere themselves.

Throughout the year, keep the parents as informed as you can about how their child is getting along with the other children. If problems do arise, you may want to ask the parents how they handle these situations at home. What do the parents do to help their child play with brothers and sisters or with neighborhood children?

You have developed a number of techniques for helping children cooperate and get along in your classroom. You will probably find that these techniques are just as useful for a child with special needs.

Teacher's Time

Assure the parents of a handicapped child that you will have time for their youngster. Describe to them what you will be doing with their child and explain that you will have your aide, volunteers, and other staff members to help you. Discuss also any outside assistance the child will be getting.

Parents may worry that their child will not make progress in your program. You can assure them that there are many things that you can teach their child, and that their child will also learn a lot from the other children in the class, too. But be careful not to offer the parents false hopes. Make it clear that you can't make long-range predictions about how far the child will progress in the future, but that you will help the child learn as much as he or she can in Head Start. Be honest when you describe the skill areas you are working on with their child, and keep them well informed of their child's progress. Ask the family, in turn, to tell you how the child is progressing at home.

As with non-handicapped children, if you genuinely like a child, and if you and other staff members in your program have worked out a sensible plan to meet the child's needs and stimulate his or her development, you have a solid basis for developing a real partnership with the parents. While parents of handicapped youngsters have some concerns that are different from the concerns of other parents, you can use the same skills and ways of working with them that you have already developed in your conversations and personal contacts with other parents.

Parents of Non-Handicapped Children

Parents of non-handicapped children in a mainstream classroom often have no strong concerns about the presence of a child with special needs in the class. If the parents of a non-handicapped child are concerned, invite them to come to your classroom to see for themselves. This will show them that a child with special needs is in many ways like other children, and that they needn't be afraid.

If some parents express a concern that their child will pick up undesirable behavior from handicapped children, you can explain to them that it is normal for children to copy the behavior of other children—this is one of the ways they learn. However, undesirable behavior tends to be outgrown quickly, once it has been tested and met with disapproval.

If parents would like to talk to their child about handicaps, you might suggest that they do this in a factual, non-emotional way. If the parents are concerned that you won't have enough time for their non-handicapped child, you can describe to them the staffing arrangements your program has made to enable all children to have enough teacher time.

In general, be calm, reassuring, and objective, and describe the very real benefits to their child of mainstreaming a child with special needs in the classroom.

Chapter 6:

Where to Find Help in Your Area

6

Working with other professionals and specialists facilitates the planning process for a child with special needs.

Head Start is a comprehensive child development program for all eligible children—handicapped and non-handicapped. It includes mainstreaming experiences in the classroom; medical, dental, mental health, and nutrition services; parent involvement; and social services to handicapped children. Head Start Programs are required to make every effort to work with other programs and agencies who serve these children. This cooperation is essential.

Provision of services to handicapped children is not a solo effort. As you have already found out (or soon will), it requires the involvement and cooperation of many people with different kinds of skills and knowledge. You are the primary planner of the child's daily educational program and the person who is central in carrying it out. But it will help you and the child if you can work with these specialists in your Head Start program and with other specialists in your community. You and the specialists can acheive more working as a team than as individuals.

This chapter begins with the case histories of three preschool-aged children with health impairments. In each case, the teacher needed to consult with other professionals or with specialists to learn how to help and work with the health impaired child. The chapter then goes on to discuss how you can find out about local or regional resources, what they provide, how you can make the most of what's available, and the kinds of specialists you may meet as you work with handicapped children.

Three Children

Kelley

When Kelley was recruited to join Ms. Thorpe's class of four-year-olds, her mother was delighted. It would give her time to prepare for the new baby's arrival in the fall, and it would give Kelley an opportunity to play with other children her age.

In the Head Start class, however, Kelley was very quiet and would sit for long periods of time painting and drawing. She would sometimes thumb through the large picture books or play alone with a doll from the doll corner. She was very reluctant to join large-group activities, and would sit quietly with little expression. She seemed generally unaware of the other children around her, and uninterested in what they were doing.

Ms. Thorpe began to be concerned about Kelley's behavior. She talked with her aide and they decided to do some systematic observation of Kelley. They discovered that Kelley would be quite busy for several minutes, then seemed to stop all activity for a few seconds, and then would get busy again. If they spoke to her during the time she was staring, Kelley did not respond. She also seemed to get very confused at transition times. She would often look around at the other children as if to make sure she was doing the right thing at the right time.

Once Ms. Thorpe was certain that this behavior was an established pattern, she decided that the next step was to ask the health coordinator about the results of Kelley's screening tests. The medical/health examination showed nothing out of the ordinary. The educational development screening also failed to indicate any further *problem areas. Since this didn't explain Kelley's unusual behavior, Ms. Thorpe decided to talk with Kelley's parents.*

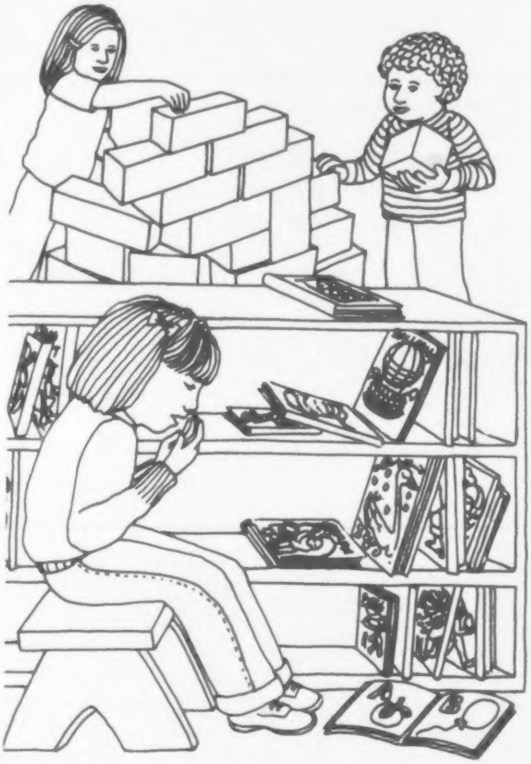
Kelley's mother said she was aware of Kelley's inconsistent behavior, and that she had been concerned with what she referred to as Kelley's "daydreaming" for a long time. The parent conference resulted in the parents making a special visit to their family doctor. She examined Kelley and advised the parents to have her seen by a pediatric neurologist. The neurologist diagnosed Kelley as having petit mal epilepsy, which caused her to have many seizures of a few seconds each throughout the day.

The seizures were what Kelley's mother had described as "daydreaming." They were also the cause of Kelley's hesitancy and confusion, which the teacher had noticed. Kelley's seizures responded to the medicine prescribed and her classroom performance improved greatly. She now enjoys preschool and is developing friends among her classmates.

Kelley's situation is typical of many handicapped preschoolers: she had symptoms that could fit into a variety of diagnostic categories, but no clear signs of underlying problems. Luckily for Kelley, the parent conference was enough to get referral and diagnosis under way. But if this had not happened, Ms. Thorpe might then have contacted the handicap coordinator or social services person, who could have handled the referral.

Jamie

Four-year-old Jamie Burk had a rather mild form of cystic fibrosis. She was checked regularly at a local clinic, and also travelled to a special cystic fibrosis center every six months for a look at her progress. She had to take enzyme tablets and salt with snack, but there were no restrictions on her activities in the program. Her coughing was only noticeable when she was playing very actively. The other children seemed to accept the matter-of-fact explanations that their teacher, Mrs. Gray, had given about the coughing and snack routine. Jamie was a cheerful, easy-going little girl who made friends easily.



84 *When Jamie returned to preschool after Christmas vacation, however, there was a marked change in her behavior. She seemed to cough almost all the time and she was very listless, wanting only to sit in the book corner or rock in the rocker. She also seemed to have a huge appetite at snack, and she kept "forgetting" to bring her enzyme tablets. Mrs. Gray became rather alarmed when this behavior continued for several days. She telephoned Jamie's home to try to find out some reason for the change in her behavior. No one answered. Mrs. Gray decided to contact the social service worker for the program and ask her to visit Jamie's home.*

The social service worker, Ms. Thomas, found that Mrs. Burk had been ill herself and had been unable to see to Jamie's needs. An older sister had been doing her best, but Jamie was not receiving her medication or aerosol inhalation treatment regularly. Ms. Thomas arranged for a temporary homemaker to help out until Mrs. Burk could recover fully. Ms. Thomas also arranged with the clinic to send a visiting nurse to supervise Jamie's medical regimen until Mrs. Burk could take over again.

In a matter of days Jamie was back to her former cheerful, outgoing self, and was able to continue in the program without further incident.

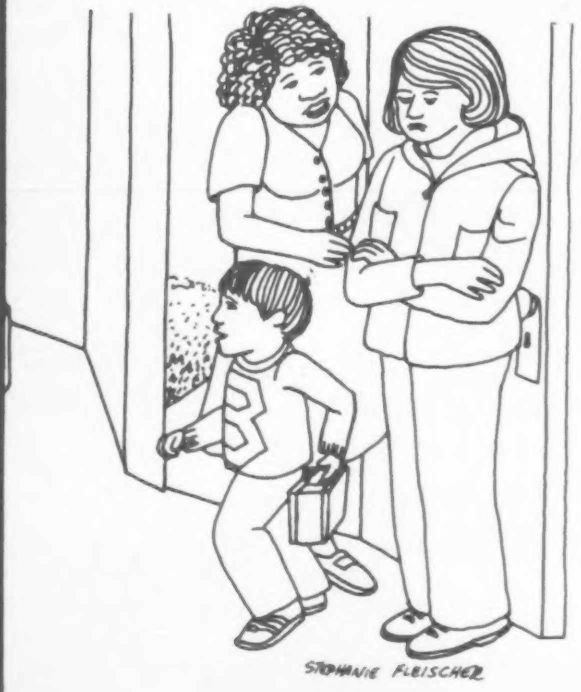
Paul

Paul, a four-year-old with diabetes, had been attending a clinical nursery school operated by the local university. His doctor, however, felt that since Paul would be entering public school the next year, it was important for him to have some contact with nonhandicapped children before going there. It would benefit all concerned, he said, if Paul could attend the Head Start program. Mrs. Jackson, Paul's mother, was concerned that Mrs. Jones, the Head Start teacher, had had little experience with handicapped children. Paul, on the other hand, was thrilled about going to preschool every day (the clinical nursery met only twice per week). He was especially excited when he learned that he would really be going on field trips to the zoo, park, and other places. His mother reluctantly agreed to enroll Paul in Head Start.

Mrs. Jones became both teacher and learner. Her most immediate problem, and one she needed advice with, was how to monitor Paul's diet during snack time. She also was unsure about how much physical activity Paul was used to engaging in at the clinical nursery. (She suspected that she was being too restrictive in her own program.) When Mrs. Jones tried to discuss her concerns with Paul's mother, Mrs. Jackson responded, "I always felt that Paul should have stayed in the clinical nursery."

Mrs. Jones then sought help from the clinical nursery staff. When Paul's former teacher compared her schedules and activities with those of the Head Start program, it became clear that Paul had been involved in a very active program at the clinical nursery. Mrs. Jones did not need to be so restrictive.

Mrs. Jones also asked Paul's mother to make several visits to the center to reassure her that Paul was "safe" and happy there. Gradually, as she came to trust the teacher and the Head Start program, Mrs. Jackson began to offer helpful advice on handling Paul's health impairment.



Finding Out About Resources

To find out about resources, start asking questions. Ask other teachers, your program director, other program staff, and then ask people they suggest. You need some basic information about the kinds of support personnel available in your program. For example:

- Is there a **handicap coordinator**, a **mental health professional**, or a **health coordinator** who is familiar with health impairments in children, and who can suggest materials, methods, and additional resources?
- Is there an **educational coordinator**, **a director of educational services**, or another **classroom teacher** who can help you to make any changes in your program as needed by a handicapped child?
- Does the program have a **social worker**, a **social services director**, or a **parent-involvement staff member** who can help arrange contacts with the child's family and with resources outside the program?
- Does your program have **consultants**, whether from the Head Start regional office; public schools; nearby colleges or universities; community health or social services agencies; a state department of education, health, or social service; or local chapters of national associations serving health impaired children? (For more information on national associations, see the section in Chapter 7 on professional and parent associations.)

Head Start Program Resources

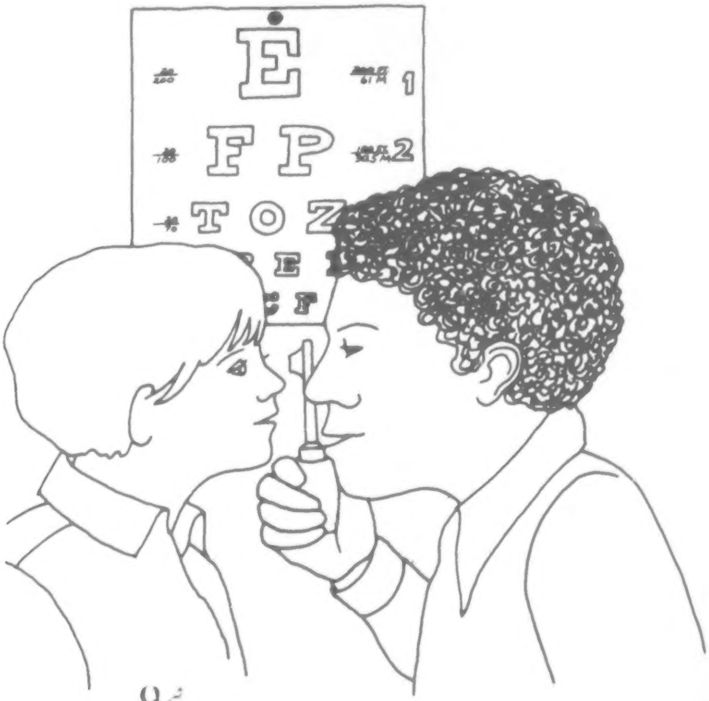
Certain components—social services, health services, educational services, handicap services, and parent involvement—are found in Head Start programs. Programs vary greatly, however, in the number of staff members providing these services.

In a given program, one person may be both the social services director and the parent involvement coordinator. In another program, several people may work in each component. These staff members may work part-time or full-time. They may be a part of your program or outside consultants to your program. Their job titles may vary. It often happens that people with the same title do different jobs, or that people with different titles do the same job. A job title only gives you a small clue. You will need to find out *who* does *what, when,* and *where,* and *how you can get things going.*

Social Services

Social services staff (whether a full-time director, a part-time social caseworker, or a community aide) usually coordinate contacts among a child's family, the Head Start program, and outside community resources. This person (or people) can help you put together a team of specialists to work with you and a health impaired child in your class. When needed, the teacher and the social services person work together to arrange referrals for children and families who need diagnosis and treatment or family counseling. Social services oversee the follow-up, too, making sure appointments are made and coordinating services if several agencies are involved. It is important that you get information from the social services person about the kinds of services a child is receiving.

The social services component is an extremely valuable resource to you in your efforts to provide handicapped children with a good education in a mainstream setting.



Health Services

The health services component of the Head Start program must include medical, dental, mental health and nutritional services. The specialists who carry out these services may work on a full-time, part-time, or consultant basis. The person responsible for coordinating all these health services can draw upon a number of services outside of the program for diagnosis and treatment. This means they can help you get health information or the services of specialists for a child. For example, an ophthalmologist or optometrist (eye specialists) may be called upon to examine a child with vision problems, or an audiologist (hearing specialist) may be recruited to assess a child's hearing. A mental health professional such as psychologist can diagnose mental retardation. Other specialists such as a neurologist (nervous system specialist), an occupational therapist (activities specialist), a physical therapist (movement specialist), or an otolaryngologist (ear, nose, and throat specialist) may be consulted when necessary.

You will want to know who in your program is responsible for contacting and coordinating health service agencies, and what your relationship is with the agencies. What kinds of assistance can you expect from them? What conference arrangements are being made among team members? While some agencies are more accessible than others, all Head Start programs (no matter how large or small) have or will have access to these resources, either within the program or through outside referrals.

Be sure that the parents are completely informed of any plans for services for their child, and that they give their consent.

Educational Services

This component comprises all aspects of the educational program. All Head Start programs, however, should use the resources of local institutions of higher learning (junior colleges, colleges, universities and University Affiliated Facilities) that are available to them.

In many programs, the people who are responsible for educational services can provide guidance and advice to teachers in the classroom. This advice would include helping you to observe the child systematically, to assess a child's skills, and to develop and carry out an individualized education plan for a health impaired child. Your center's educational director should be able to help you tailor classroom activities to meet each child's needs.

Parent Involvement

Parent involvement, a cornerstone of Head Start, encourages family participation in all aspects of the program. Head Start believes that the gains made by a child in Head Start must be understood and built upon by the child's family and by the community. To achieve parent involvement in a child's Head Start experiences, each program works toward increasing parents' understanding of their child's needs and how to satisfy them. Project Head Start is based on the premise that successful parent involvement requires parents to participate in making decisions about the program and about what kinds of activities are most helpful and important for their child.

In some Head Start programs, the parent involvement component may be combined with social services. In others, it is a separate service. Regardless of its place in the organization of your program, the people in this component are responsible for the coordination of all activities that involve the child's family.

You probably realize that the parent involvement component is especially important for families of handicapped children. Since they have lived with the child you are trying to help, they know a great deal about their child's needs and strengths. The more the home and Head Start can exchange information and work together, the better the child will do in your class.

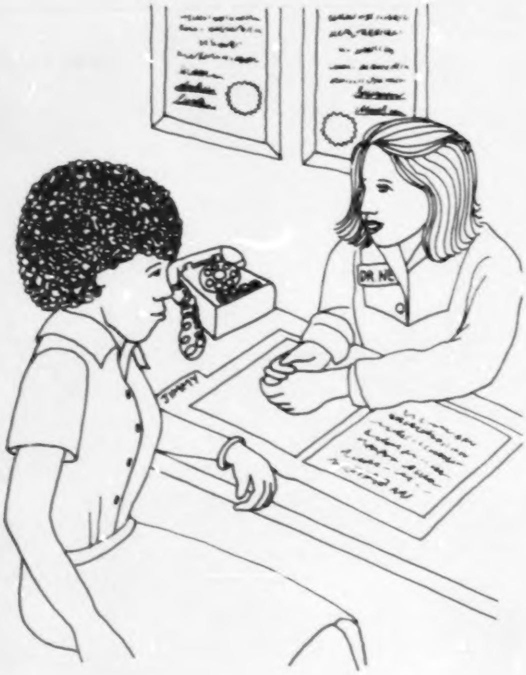
Handicap Services

A handicap coordinator is responsible for supervising the mainstreaming of all handicapped children in the program. This person is usually familiar with special education methods and materials, and should be able to teach you how to use them in your classroom if you need help.

Many Head Start programs have a close working relationship with the local school system. The local school system may pay for specialists to work with handicapped children. Under 1975 federal legislation, Education for All Handicapped Children Act (Public Law 94-142), local school districts must provide a free public education to all handicapped children from 3 to 21 years of age. Some states have their own special education laws, which require services for children from infancy to age five as well. You will want to learn as much as you can about these laws in your own state so that you can take advantage of the services. Your local public school director of special education is a good resource for such information.

One aspect of the Education for All Handicapped Children Act that concerns Head Start teachers and parents is its outreach component. Under the law, public school systems are required to demonstrate a practical method for identifying unserved and underserved handicapped children, so that they can receive the special services they need. Called Child Find, Child Search, or Child Identification in different states, the method also varies from state to state. In some, it consists of an advertising campaign to let parents, teachers, and others know whom they should contact if they suspect a child has a handicap that has not been recognized. In other states, there is a formal program of screening and diagnosis in addition to public awareness campaign. To take advantage of this service which is your right under the law, call the director of special education in your local school system, the superintendent of schools in your town, or the special education section of your state's department of education.

Since the Head Start program in many states enrolls children for whom the public school system is also responsible, this means that there are many services that the school district may be able to provide for these children in your classroom, such as free diagnoses and specialists' services. The handicap coordinator or someone else in your program should be in close contact with the public schools in your community, and should know all of the resources available and how to link up with them.



Who Knows About Resources and Services?

The staff person in your program who is responsible for handicap services may be the best person to contact to find out about resources and services. In your community, however, there are other people who know what agencies or people provide the services you need for a child with special needs.

The special education supervisor in your public school system is one person to contact for information about local resources. It is also a good idea to contact this person to alert the school system to the special needs of a child. After all, the child will probably be starting public school after leaving Head Start.

Your local hospital may have a department called a child development unit, which deals with all sorts of developmental problems in children. Sometimes the hospitals have specialty clinics for children with particular health impairments. The services the hospital can offer will vary depending on the staff and funds they have. But the hospital will often be able to suggest other resources for you to contact.

Some states have a University Affiliated Facility, which provides direct services to handicapped children and their families. The address for this resource is given in Chapter 7, page 101.

The Resource Access Project (RAP) in your region should be contacted. RAPs are designed to link local Head Start staff with a variety of resources to meet the special needs of handicapped children. They identify all possible sources of training and technical assistance and enlist their support in helping Head Start find and serve handicapped children. The addresses of the RAPs are given in Chapter 7, page 105.

Often, parents of school-age handicapped children are very knowledgeable about the resources that can be tapped. Find out if your community has an organization for parents of children with a particular health impairment.

How to Make the Most of Available Resources

You can make the most of available resources by taking the following steps:

1. Be Precise

Be precise about the help you need. For people to be helpful, they have to understand exactly what you need. You may want to discuss your problem first with other Head Start teachers and specialists, so that you end up with a clear idea of what you need to know.

2. Develop Objectives

With your team of specialists, develop objectives about what each of you wants to achieve in working with a particular handicapped child. That is, know what you're aiming for so you can plan activities to meet that aim, and so you will know when you have reached it.

3. Agree on Responsibilities

Work out together with the specialists what you expect from them and what they expect from you. People sometimes start out with different expectations—such as who's responsible for working with the child (the specialist or the teacher), or who's responsible for checking on whether the plan has worked. Responsibilities need to be spelled out so that an agreement can be reached.

4. Make Sure You Understand

Advice and explanations that don't tell you specifically what you can do for a child in your classroom leave you as stranded as you were before. If you don't understand, *ask*. Some specialists are used to saying things in complicated ways, and they need to be reminded to say them in plain English. Remember: advice won't do any good if you can't use it. And if you don't understand it, you can't use it.

5. Keep In Touch

Feedback on both sides is very important. You need to know what the specialists are doing for the child and how the child is progressing. The specialists need to know what the child is doing in your classroom and how the child is progressing. And everyone—the parents, the specialists, and you—needs to know what everyone else is doing, so that the services can be coordinated. Otherwise, two specialists could be providing the same services for a child—or even worse, no one could be providing them.

Feedback won't happen by itself. Plan a schedule of contacts (such as meetings and phone calls) and hold yourself and the specialists responsible for sticking to it.

6. Consider Parents Specialists

Work with parents in the same way that you work with specialists. Parents are specialists in their own child's needs, strengths, problems, likes, and dislikes. Furthermore, like working with specialists, working with parents involves agreed-upon objectives, knowing what each of you is doing, knowing how the child is progressing, and regular contact.

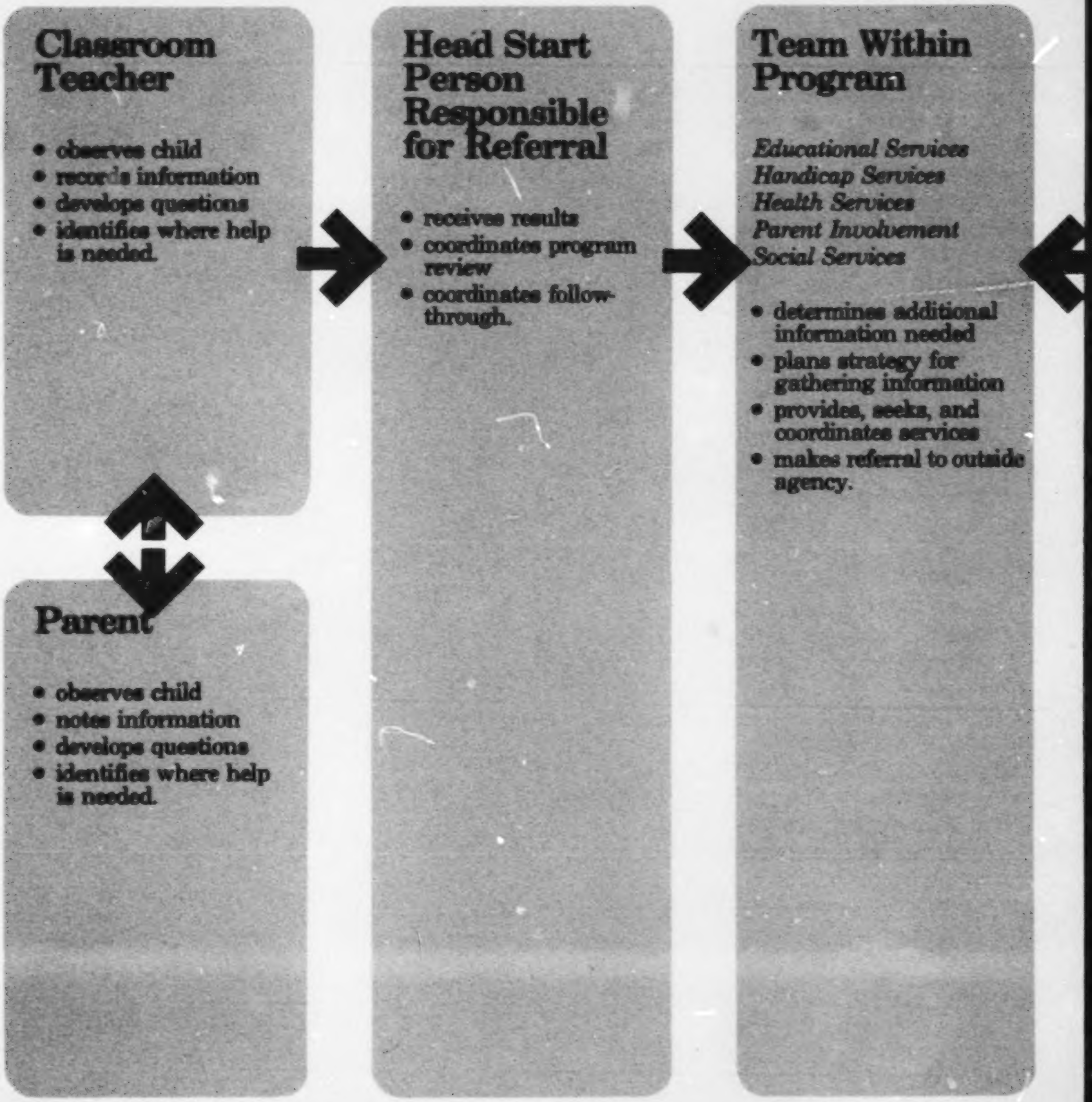
7. Expect a Lot

You will be working with a child who has problems that may be unfamiliar to you, and for which there are no easy solutions. This means you need to expect a lot, both from yourself and from others hired to help a child with special needs.

If you are going to get the most from resource persons both inside and outside your program, you need to be doing a great deal yourself. You need to identify the child's strengths and problems, and figure out how to modify your program accordingly. At the same time, you will have to maintain a program that is good for all the children in the classroom.

Expect a lot from the people your program has hired on a full-time, part-time, or consultant basis. Don't be impressed by their titles, backgrounds, or anything except, *how helpful they really are to you, the child, and the child's family.*

Using Local Resources for Mainstreaming Handicapped Children



Classroom Teacher

- observes child
- records information
- develops questions
- identifies where help is needed.

Parent

- observes child
- notes information
- develops questions
- identifies where help is needed.

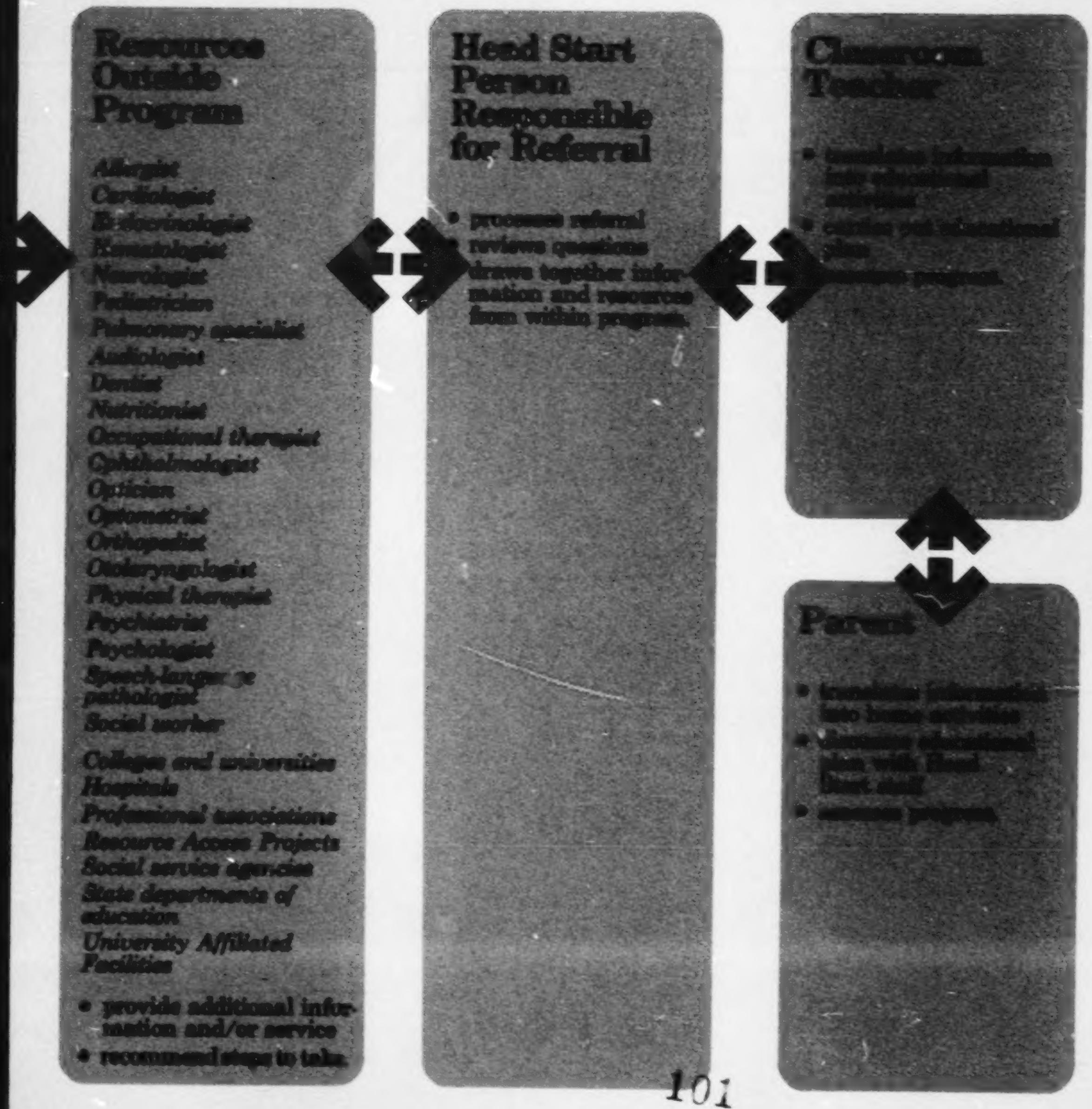
Head Start Person Responsible for Referral

- receives results
- coordinates program review
- coordinates follow-through.

Team Within Program

Educational Services
Handicap Services
Health Services
Parent Involvement
Social Services

- determines additional information needed
- plans strategy for gathering information
- provides, seeks, and coordinates services
- makes referral to outside agency.



Resources Outside Program

Allergist
Cardiologist
Endocrinologist
Hematologist
Neurologist
Pediatrician
Pulmonary specialist
Audiologist
Dentist
Nutritionist
Occupational therapist
Ophthalmologist
Optician
Optometrist
Orthopedist
Otolaryngologist
Physical therapist
Psychiatrist
Psychologist
Speech-language pathologist
Social worker

Colleges and universities
Hospitals
Professional associations
Resource Access Projects
Social service agencies
State departments of education
University Affiliated Facilities

- provide additional information and/or service
- recommend steps to take

Head Start Person Responsible for Referral

- processes referral
- reviews questions
- draws together information and resources from within program

Classroom Teacher

- translates information into educational activities
- carries out educational plan
- assesses progress

Parent

- translates information into home activities
- discusses educational plan with Head Start staff
- assesses progress

Who Are the Specialists?

What Do They Do?

For the vast majority of children, the family doctor, pediatrician, or clinic can meet all of their medical needs. This is also true for some—but not all—children with health impairments. Children with serious health impairments often are referred by a family doctor to a specialist. For example, an asthmatic child might be sent to a pediatric allergist. A child with a congenital heart defect might need to see a pediatric cardiologist. These specialists are doctors who have additional training in a specific area and who focus on problems related to health impairments.

Parents should realize that, even for a seriously health impaired child, general medical needs can still be adequately cared for by the family doctor, and should be. People specializing in specific diseases usually view their services as supportive to the family physician, and do not see to the long-term general medical needs of the child. There have been cases in which children with health impairments who did not receive the necessary childhood immunizations contracted serious illnesses such as polio and measles. Even children who are seeing specialists should have regular check ups with a pediatrician or at a clinic.

This section describes the specialists that children with specific health impairments are most likely to need help from, and the kinds of help they can provide. Other specialists who work with handicapped children are described in the section beginning on page 98.

Asthma

A child with asthma is most likely to see an* allergist *(or pediatric allergist), who specializes in allergies of the skin and respiratory system.

What Is Done

The pediatric allergist may prescribe three kinds of medicine for the asthmatic child. One kind is taken daily to prevent an attack. A second kind can be taken without medical supervision when an attack takes place. The third kind of medicine is administered only by a doctor during hospitalization for asthma.

Some children with allergies receive **desensitization** shots to reduce their "allergy" to certain weeds, pollens, grasses, and molds that they breathe. Very weak solutions of these materials are prepared and injected in small amounts into the skin of the allergic child. The child's body reacts by making materials **(antibodies)** that prevent the allergy. Stronger and stronger preparations are injected, usually at three-week intervals. Over a period of months or years the child's allergic response may be reduced to the point where fewer or less obvious symptoms appear in the presence of the allergen.

Congenital Heart Defects

A child who has been identified as having an organic heart murmur by the family doctor or pediatrician may be sent to see a* cardiologist *(or pediatric cardiologist), who specializes in heart conditions, including defects. Functional heart murmurs do not require further investigation.

What Is Done

There are numerous kinds of heart defects, some more serious than others. Some can be completely or partially corrected by surgery, while others cannot. The cardiologist will determine whether the child's heart ailment calls for regular checkups over a long period of time, special tests, medical care, or heart surgery.

Cystic Fibrosis

A child with cystic fibrosis is most likely to see a pediatric pulmonary specialist, *who specializes in the diagnosis and treatment of lung diseases in children, and a* therapist, *who could be a respiratory therapist, physical therapist, or nurse. A child might also be followed by a* gastroenterologist *or* G.I. specialist *(stomach and intestines).*

What Is Done

The child is usually seen at regular intervals of three, six, or twelve months. During a visit the child will have a physical exam, tests for bacteria, and X-rays. The parents and child may then be referred to a therapist, to learn the proper procedure for postural drainage and aerosal inhalation therapy.

Diabetes

A child with diabetes is apt to be referred to an endocrinologist *(or pediatric endocrinologist), who specializes in endocrine or metabolic disorders.*

What Is Done

The endocrinologist treats diabetes by means of dietary control and insulin. Different doctors (and clinics) prescribe different diets, some almost completely opposite from others. It is important, therefore, for each child to follow his or her individualized instructions. The endocrinologist also shows the child (or the child's parents) how to check the urine once or twice a day with a piece of treated paper that reacts to the presence and amount of sugar in the urine. The amount of insulin taken is adjusted according to the amount of sugar in the urine and the level of the child's activity. Checkups at least every three to six months are routine.

Epilepsy or Convulsive Disorders

A child with epilepsy or other convulsive disorders is most likely to see a pediatrician. *Some may be sent to a* neurologist *(or pediatric neurologist), who specializes in diseases and conditions of the brain, spinal cord, and nerves.*

What Is Done

The neurologist performs a physical examination to determine how the body gains information from the sense organs, and how it uses the muscular system to perform motor acts. He or she may do lumbar punctures and other special tests. When surgery of the nervous system is called for, the neurologist refers the patient to a neurosurgeon.

Hemophilia

A child with hemophilia requires periodic checkups with a hematologist *(or pediatric hematologist), a specialist in children's blood disorders.*

What Is Done

Simple blood tests determine if certain factors are lacking in the child's blood. If they are, the child will bleed excessively upon injury. The hematologist may recommend that the child check into a hospital for a short stay (12 to 36 hours), to have the necessary clotting factors given by venous infusion (a liquid injected directly into a vein). Sometimes this procedure can be performed at home by the parents.

Other Specialists

An **Audiologist** conducts screening and diagnosis of hearing problems, and may prescribe a hearing aid or suggest training approaches for people with hearing handicaps.

A **Dentist** conducts screening, diagnosis, and treatment of the teeth and gums.

A **Nutritionist** evaluates a person's food habits and nutritional status. This specialist can provide advice about normal and therapeutic nutrition, and information about special feeding equipment and techniques to increase a person's self-feeding skills.

An **Occupational Therapist** plans and directs activities for promoting self-sufficiency in a handicapped child. Particular attention is paid to improving fine motor skills, such as those involved in eating and dressing.

An **Ophthalmologist** is a medical doctor who conducts screening, diagnosis, and treatment of diseases, injury, or birth defects that limit vision.

An **Optician** assembles corrective lenses and frames. He or she will advise in the selection of frames and fit the lenses prescribed by the optometrist or ophthalmologist to the frames. An optician also fits contact lenses.

An **Optometrist** examines the eyes and related structures to determine the presence of visual problems and/or eye disease, and to evaluate a child's visual development.

An **Orthopedist** is a medical doctor who conducts screening, diagnosis, and treatment of diseases and injuries to muscles, joints, and bones.

An **Otolaryngologist** is a medical doctor who conducts screening, diagnosis, and treatment of ear, nose, and throat disorders.

A **Physical Therapist** evaluates and plans physical therapy programs and directs activities for promoting self-sufficiency primarily related to gross motor skills such as walking, sitting, and shifting position. He or she also helps people with special equipment used for moving, such as wheelchairs, braces, and crutches.

A **Psychiatrist** conducts diagnosis, and treatment of psychological, emotional, behavioral, and developmental or organic problems. Psychiatrists can prescribe medication. They generally do not administer tests. There are different kinds of psychiatrists.

A **Psychologist** conducts screening, diagnosis, and treatment of people with social, emotional, psychological, behavioral, or developmental problems. There are many different kinds of psychologists.

A **Social Worker** provides services for individuals and families experiencing a variety of emotional or social problems. This may include direct counseling of an individual, family, or group; advocacy; and consultation with preschool programs, schools, clinics, or social agencies.

A **Speech-Language Pathologist** conducts screening, diagnosis, and treatment of speech and language problems. This specialist may also be called a **speech clinician** or **speech therapist.**

Chapter 7:

Other Sources of Help

There are many associations and books that can provide more detailed information on mainstreaming children with health impairments.

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In addition to the specialists in your program, community, or region, there are other sources of help you can draw on to assist you with children who are health impaired. Around the country are a number of associations and organizations concerned with particular health impairments. They can provide general information about health impairments, and specific information about what you can do with health impaired children in the classroom. There are also many good books and articles that you may find useful. These are listed in the bibliography at the end of this chapter.

Professional and Parent Associations, and Other Organizations

For the associations and organizations in this section, we have listed their national addresses, whether they have local branches, what they do, and how they can help you.

American Alliance for Health, Physical Education and Recreation

This organization provides information and materials on physical education and recreation for people with handicaps. For information write to:

Physical Education and Recreation for the Handicapped Information and Research Utilization Center

American Alliance for Health, Physical Education and Recreation
Room 422
1201 16th Street
Washington, D.C. 20036

American Association of University Affiliated Programs

This organization is most interested in providing diagnostic services to individuals with developmental disabilities and in providing training for people who work with handicapped persons. University Affiliated Facilities provide services in areas such as early childhood and special education, pediatrics, child development, child psychology, social work, child neurology, speech pathology, physical and occupational therapy, nutrition, and nursing. Nearly 50 UAFs have been established throughout the country. The association has an official working relationship with Head Start. By writing to the address below you can find out if there is a program near you that can provide diagnostic, treatment, training, and consultation services. For more information write to:

American Association of University
Affiliated Programs
Suite 406
2033 M Street
Washington, D.C. 20036

American Diabetes Association

The American Diabetes Association is concerned with the detection of diabetes; research; and professional, patient, and public education. Local affiliates can make referrals to medical and community resources. Many sponsor summer camps for diabetic children. Publications cover patient education, professional education, and health education. To contact your local affiliate, check your telephone book or write to:

American Diabetes Association
600 Fifth Avenue
New York, New York 10020

American Heart Association

The American Heart Association is a voluntary health agency whose mission is to reduce premature death and disability from cardiovascular diseases (diseases of the heart and blood vessels). The Association recognizes three general areas of program responsibility: research, community programs, and public and professional education.

Local Heart Associations are distributed throughout the United States and Puerto Rico, and are responsible for serving their assigned areas. While they do not give financial aid directly to individuals, they provide leadership in working for and supporting organized community efforts that will assist such individuals. Check your telephone listings for your local Heart Association.

Among their publications are "A Guide for Teachers: Children with Heart Disease" and "If Your Child Has a Congenital Heart Defect." To obtain these and other materials or for more information, call your local Heart Association or write to:

American Heart Association
7320 Greenville Avenue
Dallas, Texas 75231

Closer Look

Funded through the Bureau of Education for the Handicapped, U.S. Office of Education, this special project attempts to provide bridges between parents and services for handicapped children, and to help parents become advocates for comprehensive services for their own handicapped child as well as for others. Closer Look publishes a newsletter about handicaps and new programs, as well as information of special interest to parents. The staff will also respond to questions that you may have. The newsletters and information are free. By writing to Closer Look you can be added to their mailing list.

This organization has regional branches. For more information write to:

Closer Look
Box 1492
Washington, D.C. 20013

Council for Exceptional Children Information Center

This information center provides abstracts of current research and bibliographies of information currently available in publications and nonprint media. It also provides annotated listings of agencies that serve exceptional children and their families. Contact:

Council for Exceptional Children
Information Center
1920 Association Drive
Reston, Virginia 22091

Cystic Fibrosis Foundation

The Cystic Fibrosis Foundation encourages and coordinates research, supports over 100 Cystic Fibrosis Centers, provides information, and works toward the improvement of diagnostic and treatment services. The 100 centers also provide help for all serious lung and gastrointestinal disorders in children, as well as for cystic fibrosis. Local programs offer many services, which may include parent education and low-cost drug and equipment programs. The Foundation publishes booklets for both teachers and parents. For more information, write to:

Cystic Fibrosis Foundation
3379 Peachtree Road, N.E.
Atlanta, Georgia 30326

Epilepsy Foundation of America

The Epilepsy Foundation of America is a national voluntary health organization. It acts as a national spokesperson and advocate for people with epilepsy, and supports medical, social, and informational programs. The Foundation offers many low-cost and free publications that teachers and parents [illegible] health impaired children have found helpful. In addition, ten issues a year of the **National Spokesman** are available by subscription.

The Epilepsy Foundation has local chapters. For more information write to:

Epilepsy Foundation of America
1828 L Street, N.W.
Washington , D.C. 20036

Instructional Materials Centers

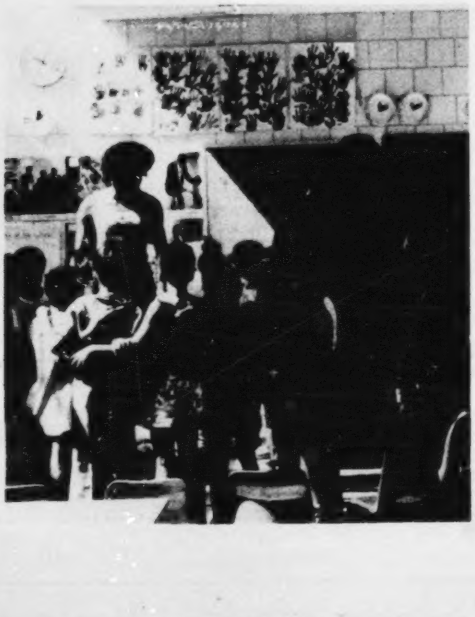
These centers have media and materials suitable for use with handicapped children. Often the director or staff of the center can demonstrate materials, suggest especially good materials, and consult with you about your needs.

To find out about a Center, contact the Resource Access Project in your region, directors of special education in your state department of education, or special education departments at nearby colleges and universities.

National Center for Law and the Handicapped, Inc.

This organization was established to ensure equal protection under the law for handicapped people. It participates in selected court cases by consulting with the lawyers of handicapped people whose rights may have been violated. Sometimes NCLH provides a lawyer for a handicapped person. The staff can answer questions and provide information about legal issues affecting children with health impairments. For more information write to:

National Center for Law
and the Handicapped, Inc.
1235 North Eddy Street
South Bend, Indiana 46617



National Epilepsy League

This organization is dedicated to working for a better public understanding of epilepsy and for meeting the needs of epileptics. To achieve this, N.E.L. has developed a training manual on epilepsy called **The Total Rehabilitation of Epileptics,** developed programs that are directed to the specific needs of epileptics, founded a pharmacy to distribute prescribed medication at discount prices, and worked with insurance companies to bring basic insurance coverage to epileptics. The league's newspaper, **Horizon,** is designed to educate epileptics and others on the disorder, and to keep them informed of new developments. For more information write:

National Epilepsy League
6 North Michigan Avenue
Chicago, Illinois 60602

The National Foundation/ March of Dimes

The National Foundation/March of Dimes has as its goal the prevention of birth defects. Its principal programs and activities include funding basic and clinical research, funding medical service programs, offering professional education, and providing health information. The foundation publishes pamphlets, booklets, and audio-visual materials for the general public on the prevention and treatment of birth defects.

March of Dimes has local chapters. For more information write to:

The National Foundation/
March of Dimes
1275 Mamaroneck Avenue
White Plains, NewYork 10605

The National Hemophilia Foundation

The National Hemophilia Foundation is a national, nonprofit health organization with the following objectives: to organize and develop a national program of research and clinical studies in the field of hemophilia; to develop and expand the foundation, its benefits, and facilities to areas throughout the country not now served; to publish information and knowledge relating to early diagnosis and correct treatment of hemophilia; to organize a national fund-raising program and to advise and assist chapters.

There are 50 affiliated chapters located throughout the country. The foundation and its chapters prepare educational materials for general and professional use, as well as for patients and their families. In addition, a quarterly newsletter and a number of pamphlets are available. For more information write to:

The National Hemophilia Foundation
25 West 39th Street
New York, New York 10018

National Kidney Foundation

The National Kidney Foundation deals primarily in the distribution of public and professional educational materials and in referrals to affiliates. Affiliates provide information and advice on community facilities. Contact:

National Kidney Foundation
116 East 27th Street
New York, New York 10010

Resource Access Projects

Resource Access Projects (RAPs) are designed to link local Head Start staff with a variety of resources to meet the special needs of handicapped children. They function as brokers, facilitating the delivery of training and technical assistance to meet local Head Start program needs in the area of services to handicapped children. While the RAPs will assist local grantees in determining and meeting their needs in the area of handicapped services, the cost of any required training or technical assistance must be borne by the grantee and/or the resource provider.

RAPs have been established to identify all possible sources of training and technical assistance, and to enlist their support in helping Head Start find and serve handicapped children. Examples of resources include public health departments, community mental health centers, speech and hearing clinics, developmental disabilities councils, universities and colleges, professional associations, and private providers of training, technical assistance, materials and equipment.

DHEW Region	States Served	Resource Access Project (RAP)
1	Maine New Hampshire Vermont Connecticut Massachusetts Rhode Island	Education Development Center, Inc. 55 Chapel Street Newton, Massachusetts 02160
2	New York New Jersey Puerto Rico Virgin Islands	New York University School of Continuing Education 3 Washington Square Village, Apt. 1M New York, New York 10012
3	Pennsylvania West Virginia Virginia Delaware Maryland District of Columbia	PUSH/RAP Mineral Street Annex Keyser, West Virginia 26726
4	North Carolina South Carolina Georgia Florida Mississippi	Chapel Hill Training Outreach Project Lincoln School Merrit Mill Road Chapel Hill, North Carolina 27514
	Kentucky Tennessee Alabama	**The Urban Observatory** 1101 17th Avenue, South Nashville, Tennessee 37212
5	Illinois Indiana Ohio	University of Illinois Colonel Wolfe Preschool 403 East Healey Champaign, Illinois 61820
	Minnesota Wisconsin Michigan	**Portage Project** **Resource Access Project** 412 East Slifer Street P.O. Box 564 Portage, Wisconsin 53901
6	Texas Louisiana Oklahoma Arkansas New Mexico	Contract not awarded at time of printing.

DHEW Region	States Served	Resource Access Project (RAP)
7	Missouri Kansas Iowa Nebraska	University of Kansas City Medical Center Children's Rehabilitation Unit 39th & Rainbow Blvd. Kansas City, Kansas 66103
8	Colorado North Dakota South Dakota Montana Utah Wyoming	Mile High Consortium Hampden East I-Room 215 8000 East Girard Avenue Denver, Colorado 80231
9	California Arizona Hawaii Nevada Pacific Trust Territories	Los Angeles Unified School District Special Education Division 450 North Grand Avenue Los Angeles, California 90012
10	Washington Oregon Idaho	University of Washington Model Preschool Center for Handicapped Children Experimental Education Unit WJ-10 Seattle, Washington 98195
	Alaska	Easter Seal Society for Alaska Crippled Children and Adults 726 E. Street Anchorage, Alaska 99501

Bibliography

Every Head Start center or other preschool should have a good first-aid book on hand at all times. One such book is:

Green, Martin I. **A Sigh of Relief: The First-Aid Handbook for Childhood Emergencies.** New York: Bantam Books, 1977.

Many books have been published on children with health impairments. It is not possible to list all of them here. The ones mentioned are some of those that are especially good for understanding the various health impairments and for helping you work with health impaired children in your classroom.

Books About Health Impairments

Bleck, Eugene E., and Nagel, Donald A., eds. **Physically Handicapped Children—A Medical Atlas for Teachers.** New York: Grune and Stratton, 1975.

This handbook for teachers of handicapped children contains fundamental medical facts and practical suggestions for working with handicapped children in special or regular classes. Medical terminology is explained, and drawings are simplified.

Hardgrove, Carol. **Parents and Children in the Hospital: The Family Role in Pediatrics.** Boston: Little, Brown and Co., 1972.

A very useful book in helping parents prepare for their child's hospitalization.

Lagos, Jorge C. **Seizures, Epilepsy and Your Child.** New York: Harper and Row, 1974.

This is an excellent book for parents and teachers who have questions about epilepsy. Written in a question-answer format.

Spock, Benjamin, and Lerrigo, Marion. **Caring for Your Disabled Child.** New York: Macmillan Co., 1965.

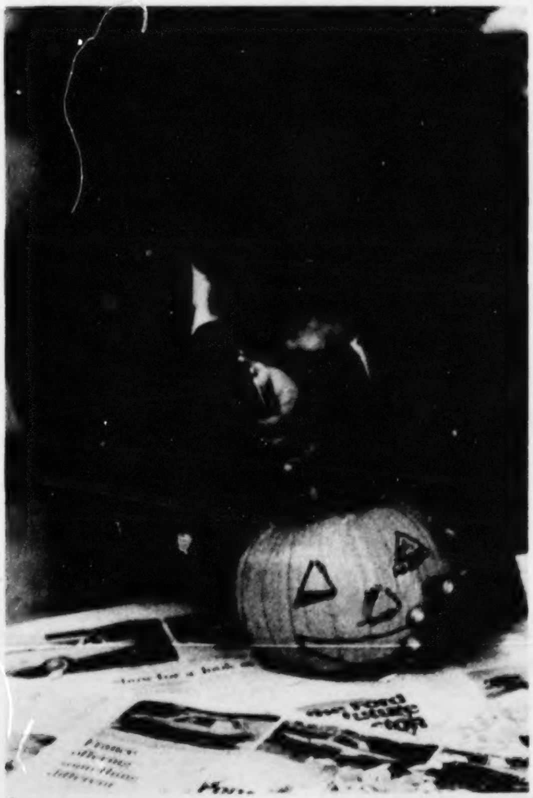
This is an excellent reference book for parents, containing suggestions on medical care, education, and home management.

Travis, Georgia. **Chronic Illness in Children: Its Impact on Child and Family.** Stanford, Calif.: Stanford University Press, 1976.

Written for people who work with handicapped children and their families. Includes descriptions of various conditions and their causes, symptoms, and effects (both physical and emotional) upon children at different age levels. Methods of diagnosis and treatment are also described.

Weiner, Florence. **Help for the Handicapped Child.** New York: McGraw-Hill Book Co., 1973.

This is an excellent source of information on handicapping conditions and the services available. It is organized by condition, and includes information on treatment, prognosis, medical progress, future medical goals, tests, service agencies, voluntary associations, and vocabulary.



Books for Children

Beim, Jerold. **The Smallest Boy in the Class.** New York: William Morrow and Co., 1951.

The smallest boy in class learns that size is not all that important.

Fassler, Joan. **One Little Girl.** New York: Behavioral Publications, 1969.

This story about a little girl whom grownups call "slow" helps children understand the feelings of other children.

Green, Mary **Is It Hard? Is It Easy?** New York: William R. Scott, 1960.

A boy and girl find that different things are hard and easy for them.

Rey, M. **Curious George Goes to the Hospital.** Boston: Houghton Mifflin Co., 1966.

The famous monkey and his antics in the hospital help cheer up an unhappy young patient.

Salazar, Violet. **Squares Are Not Bad.** Racine, Wis.: Golden Press, 1967.

This picture book is about circles who learn to accept squares.

Stein, Sara B. **A Hospital Stay: An Open Family Book for Parents and Children Together.** New York: Walker and Co., 1974.

This is an excellent book to help prepare children aged three to eight for hospitalization.

Stein, Sara B. **About Handicaps: An Open Family Book for Parents and Children Together.** New York: Walker and Co., 1974.

An excellent story about handicaps. Simple text and beautiful photographs. A companion text for teachers and parents provides help in answering questions children may raise about handicaps.

Guides to Teaching and Classroom Activities

D'Audney, Weslee, and Dollis, Dorothy. **Calendar of Development Activities for Preschoolers** (1975). Available from Meyer Children's Rehabilitation Institute, University of Nebraska Medical Center, Omaha, Nebraska, 68105.

This is a resource book on preschool activities, arranged in calendar format. The simpler activities are presented in the fall months and the more complex ones are presented in the spring months, allowing you to choose activities that are appropriate to the child's development level. Also given are the skill areas involved in each activity.

D'Audney, Weslee, ed. **Giving a Head Start to Parents of the Handicapped** (1976). Available from Meyer Children's Rehabilitation Institute, University of Nebraska Medical Center, Omaha, Nebraska, 68105.

This manual is designed primarily to help Head Start teachers provide support and encouragement to parents of children with handicaps. It discusses subjects such as the value of mainstreaming, legal rights of the handicapped and their families, and the dangers of labeling. It also provides specific suggestions for working with parents of special needs children.

The Exceptional Parent Magazine. Psy-Ed. Corporation, 20 Providence Street, Room 708, Statler Office Building , Boston, Massachusetts 02116.

Addressed to the parents and teachers of handicapped youngsters and adults, this magazine has many articles of interest, including "how to," "what to do," and "where to get help."

For a subscription, write to: The Exceptional Parent, P.O. Box 641, Penacook, New Hampshire 03301.

Findlay, Jane, et al. **A Planning Guide: The Preschool Curriculum—The Child, The Process, The Day.** Chapel Hill, N.C.: Chapel Hill Training Outreach Project, n.d.

This book elaborates on curriculum information found in the **Learning Accomplishment Profile,** developed by Anne Sanford, and presents 44 preschool curriculum units intended for developmentally delayed or impaired children. It has a section on curriculum (who determines it, what it is, and what goes into it), a section on methods and principles (preparing instructional objectives, task analysis, error-free learning, and positive reinforcement), the 44 curriculum units, with objectives and skill sequences, and bibliographies. It is helpful, although not necessary, to use the Planning Guide together with the LAP.

Hogden, Laurel, et al. **School Before Six: A Diagnostic Approach.** Available from Cemrel, Inc., 3120 59th Street, St. Louis, Missouri, 63139

School Before Six is printed in two volumes. Volume I includes procedures for assessing young children's learning needs and strengths through testing procedures in four developmental areas: large, small, and perceptual motor skills; language; socio-emotional skills; and conceptual skills. General teaching strategies and activities are suggested to help children develop in each of these areas. Volume II includes a wealth of activities in areas such as science, art, table games, food preparation, language, social science, and music. Volume I is extensively cross-referenced to Volume II to make the selection of appropriate activities for specifically diagnosed situations easy.

Jordan, June, ed. **Not All Little Wagons Are Red: The Exceptional Child's Early Years.** Available from: CEC Information Center, Special Education IMC/RMC Network, 1920 Association Drive, Reston, Va. 22091

This book discusses the importance of beginning early to develop programs for children with handicaps. Attention is given to helping children achieve a positive self-concept, good learning motivation, social skills, emotional stability, and physical well-being. Two sections are particularly helpful: one on the development of children needing special help, and the other on program models and resource materials. The book includes many fine illustrations, and describes a variety of alternative ways to meet children's needs.

The Portage Guide to Early Education, rev. ed. Portage, Wis.: Cooperative Educational Service Agency No. 12, 1976.

This guide includes three parts: a checklist of skills for determining an individual child's progress, a card file listing activities that can be used to teach these skills, and a manual of directions for conducting the activities. The areas covered in the program are: infant stimulation, socialization, language, self-help, cognitive skills, and motor skills.

Teaching Exceptional Children. Available from: CEC Information Center, Special Education IMC/RMS Network, 1920 Association Drive, Reston, Va. 22091

This magazine provides many ideas for working with exceptional preschool children.

Tucker, Dorothy; Seabury, Barbara-Jeanne; and Canner, Norma. **Foundations for Learning with Creative Art and Creative Movement.** Boston: Division of Mental Health, Department of Mental Health, 1967.

This book, originally developed for Massachusetts Head Start, is a good source of curriculum ideas in the areas of language and communication, large and fine motor development, and sensory and body image.

A Selected Guide to Public Agencies Concerned with Exceptional Children. Available from CEC Information Center, Special Education IMC/RMC Network, 1920 Association Drive, Reston, Va. 22091

This is an annotated listing of agencies that offer services to exceptional children and their families.

Films, Slide Tapes, and Other Materials

For Teachers and Parents

Care Through Parents: Creating a New Space in Pediatrics,
Carol Hardgrove.

16 mm color film, 14 minutes.

Available from Extension Media Center, University of California, Berkeley, California 94720.

This film describes the ways in which parents can participate in the care of their hospitalized child, and tells why such support is essential to the child's well-being. It shows how parents can be integrated into the life of a pediatric unit through rooming-in, and how family members and professionals may interact to the benefit of all concerned, especially the very young patient.

Each Child, Every Child (1974). Produced by the American Academy of Pediatrics and University Hospital School, Iowa City, Iowa.

16 mm color slide tape.

Available from the Audio-Visual Department, University of Iowa, Iowa City, Iowa 52242.

Describes general methods of evaluating all Head Start children for health and handicapping conditions. Appropriate suggestions are included on the preparation of a plan to meet the social, educational, and treatment needs of a child with a handicap in Head Start.

To Prepare a Child. Produced by the Children's Hospital National Medical Center, Washington, D.C.

16 mm color film, 32 minutes.

Available from the Media Center, Children's Hospital National Medical Center, Washington, D.C. 20010

This film is a documentation of three real children, their families, and their hospital experiences: eight-year-old Ivan, a cardiac patient; five-year-old Kathy, a short-term surgical patient; and Jason, a four-year-old emergency room patient. "To Prepare a Child" urges medical and educational professionals and parents to evaluate—and perhaps change—their current thinking about the process of preparing children for hospitalization. A companion film for children is also available: "A Hospital Visit with Clipper" (see films for children).

We Won't Leave You, by Edward A. Mason, M.D.

16 mm color film, 17 minutes.

Available from Edward A. Mason, M.D., Films, 58 Fenwood Road, Boston, Massachusetts 02115.

Documentation of five-year-old Heather's hospital experience, involving surgery for bilateral hernias. The film focuses on the emotions of the child and her parents, rather than on hospital details, although it offers sufficient specific information to be helpful to parents who are preparing a child for hospitalization. It is also helpful to staff of pediatric services, and to teachers of preschool-aged children.

112 **When a Child Enters the Hospital.** Text and narration by Muriel Sugarman, M.D.

16 mm color film, 16 minutes.

Available from Polymorph Films, 331 Newbury Street, Boston, Massachusetts 02115.

This film examines the hospital experience of Michele, a young girl who is undergoing minor surgery, and Michele's mother, who is rooming-in. The film shows how parent involvement works. The commentary explains what is happening to Michele, and her feelings and needs. It also discusses in general terms problems related to the hospitalization of children. The film is intended as a realistic guide for parents and staff, although preschool teachers will also find it enlightening.

For Children

A Hospital Visit with Clipper. Produced by the Children's Hospital National Medical Center, Washington, D.C.

16 mm color film, 15 minutes.

Available from the Media Center, Children's Hospital National Medical Center, Washington, D.C. 20010

This filmed adaptation of a show by the Bob and Judy Brown Puppet Theatre can serve as an entertaining and informative introduction to the hospital for children aged three through ten. In the film, Nurse Brown and Clipper the Clown help make unfamiliar faces, strange procedures, equipment, and the prospect of pain less frightening to patient Polly Sue. The film can help parents and educators prepare themselves and young children for a hospital experience.

Appendix

Tests are only one source of information in evaluating a child.

Screening and Diagnosis

This section describes the nature and purpose of screening and diagnosis, and the use of tests in each of these processes. The overall goal of both processes is to evaluate or assess a child's functioning and to identify problem areas, if any exist.

Screening

Screening is a process that identifies children who need specific treatment (for example, eyeglasses or immunization shots) **or who need to be referred for a diagnostic evaluation.** Screening is therefore an important tool in the early identification of handicapped children.

Screening procedures such as checklists and tests are inexpensive, quick, and easily administered. They give the screener an overview of a child's performance. Teachers, aides, and others need to be trained to use a particular screening procedure correctly. For the screening services that must be provided for every child, see Project Head Start Performance Standards.

Not all children who fail a screening test are found to have a problem when they are given a full diagnostic evaluation. This is because the results of screening tests are not exact, since the tests do not assess in depth a child's functioning in a given area. Also, because screening is done in a limited amount of time, the screener may not realize if a certain child is not performing at his or her best at that particular time. For these reasons, a child who is not handicapped may fail a screening and be referred for further evaluation.

On the other hand, some children who pass a screening test may, in fact, have a problem that wasn't detected in the screening. If you have a child in your class who has passed the standard screening tests and you still feel there may be something wrong, do not hesitate to ask an appropriate professional to look at the child more closely.

Diagnosis

Diagnosis is a process of gathering information from a variety of sources in order to get a comprehensive picture of a child's functioning and to identify problem areas. The diagnostic process assesses both physical and psychological functioning.

A variety of tools should be used in the diagnostic process: interviews (with parents and other adults who know the child well, with the child, with social agency personnel the child has been receiving services from), psychological tests, medical and other reports/tests of physical functioning, and other sources of information about the child. The tests that are used in the diagnostic process take an in-depth look at a child's skills in particular developmental areas. In Project Head Start, diagnosis is to be conducted by an interdisciplinary team of specialists (or a professional who is qualified to diagnose the specific handicap). The diagnostic process should involve:

1. A categorical diagnosis of a child, using Project Head Start diagnostic criteria, to be used solely for reporting purposes.

2. A functional assessment of a child. This functional assessment is a developmental profile that describes what the child can and cannot currently do and that identifies areas requiring special education and related services.

3. An individualized program plan based upon the functional assessment and developed jointly by the diagnostic team, the parents, and the child's teacher.

4. Ongoing assessment of the child's progress by the teacher, the child's parents, and (as needed) the diagnostic team.

The results of the diagnostic process should inform the teacher and parents as to the child's strengths and weaknesses—and hence the child's needs in terms of further learning. The results of the diagnostic process often *do not* tell the teacher or parents what they should do to help the child in the identified problem areas. Diagnosticians themselves, depending on their knowledge of classrooms and of specific teaching techniques, may be able to discuss with the teacher and parent specific ways in which they can help the child in the classroom and at home. Often the teacher or parent needs to take the initiative in order to obtain this kind of information from a diagnostician.

Testing

The selection of appropriate tests, their administration, and their interpretation is often a difficult process, requiring a great deal of expertise. Sometimes the precise test needed has simply not yet been developed, and a diagnostician must use the best of what is available and then interpret the results with great caution. Many factors can lead to inappropriate testing or inaccurate test results:

- **mistaking one handicap for another**
- **mistaking cultural differences for handicaps**
- **mistaking normal physical or mental immaturity for handicaps**
- **testing a child who is not used to test-like situations**
- **testing a child when he or she is not feeling well**
- **testing a child in a language that is not his or her home language**
- **testing a particular developmental area in a child by requiring a response that involves skills in which the child is handicapped (for example, testing cognitive functioning by requiring a verbal response from a speech impaired child, or a motor response from an orthopedically handicapped child).**

Even if children are given tests that are appropriate to their age, cultural background, and suspected handicaps—and that are methodologically valid and reliable—test results can be inaccurately interpreted.

To ensure the tests are appropriate to a specific purpose, and that they are administered and interpreted correctly, any screening test that a teacher wants to use should be discussed ahead of time with a trained professional who is knowledgeable about the test. Tests used for diagnostic purposes should be administered and interpreted by specialists trained in the use of the test.

In addition to interviews and histories, your own continuing observation of a child in a variety of situations in your preschool program is an invaluable tool in understanding and helping a child learn. During the preschool years, children experience a great amount of development and change in all areas. This means that ongoing assessment, balanced against over-testing, is needed to provide a more accurate picture of a child's developing skills and functioning. Ongoing assessment can help prevent mislabeling of children.

For additional information on the diagnostic process—including procedures and persons—contact the Resource Access Project in your area.

For additional information on tests, write:

Head Start Test Collection
Educational Testing Service
Princeton, New Jersey 08540

Medical Tests

The tests described below are used specifically with health impaired children, or with children who are suspected of having a health impairment.

In **amniocentesis,** a sample of amniotic fluid (the fluid in the uterus) and cells from the fetus's skin is taken by a needle through the abdomen of a pregnant woman. The fluid and skin cells are checked to see whether certain diseases or conditions are present in the fetus (for example, Down's syndrome, spina bifida). The procedure entails minimal risk to the baby. The mother's skin is injected with pain-killing medication; she experiences mild to moderate discomfort.

Angiography: see cardiac catheterization.

Anticonvulsant medication level is a blood test to determine whether a child with a neurological disorder is receiving enough of the medication to control seizures.

In a **barium enema,** a material (barium) that allows X-rays to be taken is inserted in the rectum. X-rays of the rectum and large bowel can allow a doctor to detect problems that are causing chronic constipation or diarrhea. The procedure causes mild discomfort.

A **biopsy** is a small sample of any body tissue (skin, liver, and kidney tissue are common examples). The sample is taken for examination in a laboratory. In **open biopsy,** a cut is made to remove a piece of tissue. In **needle biopsy,** a needle is inserted to draw out a small amount of tissue. The procedure causes mild to moderate discomfort.

For a **blood count**, a small amount of blood is taken from the arm to check for anemia or infection. This is done by counting the numbers of red and white blood cells, and checking the kinds of white blood cells and the redness or richness of the blood.

In a **blood sugar test**, a small amount of blood is taken from the finger or arm to measure the amount of sugar in the blood.

A **blood test** is a general term that can indicate a wide variety of tests (such as blood count, blood sugar test).

In a **bone marrow test**, a needle is inserted into a bone (usually the hip bone), to collect a small sample of blood from the marrow or center of the bone, where most of the blood is made. Pain-killing medication is given; there is moderate discomfort.

In **cardiac catheterization**, a thin tube is inserted into a vein in the elbow or groin, and passed into the heart. This allows a doctor to measure the amount of oxygen and the pressure in the different parts of the heart and vessels. In **angiography**, a dye is injected into the heart to allow X-rays to be taken. The child is sedated (given sleeping medicine) during this procedure.

In a **chromosome test**, a sample of skin, blood, or other body tissue is taken in order to count the number of chromosomes present. There are normally 48 chromosomes in every cell, which carry the genes that determine a person's makeup. In Down's syndrome (Mongolism) there is an extra chromosome. The test is very time-consuming and expensive.

In order to do a **culture**, blood, urine, or throat secretions are taken. These samples are tested in the laboratory to see whether bacteria are present.

In an **electrocardiogram** (ECG), a series of wires are pasted on the skin of the chest so that a machine can measure the electrical activity of the heart. The test is not painful, and takes only about five minutes.

In an **electroencephalogram** (EEG), a series of wires are pasted on the skin of the scalp in order to perform a brain wave test. The electrical activity of the brain is measured twice: once while the child is awake, and once while the child is asleep (sometimes a sleeping pill is given to the child). The test may last from 30 to 90 minutes, and is not painful.

In **electromyography** (EMG), a series of wires are pasted on the skin or a needle is inserted into a muscle to measure the electrical activity of the muscle. This test is used in conditions such as muscular dystrophy. The test may cause moderate discomfort or mild pain if needles are used.

The **EMI** or **CAT Scan** is one of the newest kinds of X-ray machines. It takes many "pictures" and stores them in a computer that can print out a picture of the body part that is being tested. The test is not painful, but sometimes a sleeping pill is given to help the child lie quietly.

A **glucose tolerance test** is used to detect diabetes. The child swallows a measured amount of sugar and blood sugar tests are done for the next few hours (see blood sugar test).

Lumbar tap: See spinal puncture

In a **metabolic screen**, a sample of blood or urine is collected and tested for a variety of inherited disorders (such as PKU) that cause abnormal development in children. If the results of one of these screening tests is abnormal, special tests are performed to detect the specific disease.

A neurologic test checks the functioning of the brain, spinal cord, and nerves by testing vision, hearing, mental alertness, mood, muscle strength, and coordination, among other things. If problems are found, many other tests can be included to determine the specific disease or condition.

A serology is a general blood test used to detect antibodies in the blood. It has a wide variety of applications.

In **sigmoidoscopy,** a tube is inserted about 10 inches into the rectum, so that a doctor may look at the inside of the lower bowel. The procedure is usually called for in cases of chronic diarrhea. There is mild to moderate discomfort. Pain-killing medication is usually given.

Skin allergy tests are performed to determine the allergen, or substance to which the child is allergic. Weak solutions of materials such as pollens, dust, or molds are injected into the skin. If the injected area becomes red, swollen, and itchy, the reaction is called "positive." "One plus" means a very mild reaction; "two plus" is a mild reaction; "three plus" means a moderate reaction; "four plus" indicates a severe reaction.

In a **spinal puncture** (also called a **lumbar tap**), a small needle is inserted into the lower back to withdraw a few drops of spinal fluid. The test is usually done when meningitis or infection of the spinal cord are suspected. The procedure is mildly painful.

In a **sweat test,** wires are pasted onto the skin of the arm to make the skin sweat. Blotter paper is then used to collect the sweat, which is checked for salt content. If too much salt is being lost through the skin, cystic fibrosis may be suspected. The test causes very mild discomfort.

A tine test is a type of skin test used to determine whether a person now has or has had tuberculosis. A similar but different test is the **PPD** (purified protein derivative) of tuberculosis. Patch tests are no longer used.

In the **upper gastro-intestinal (GI) series,** the child drinks material that allows X-rays to be taken of the stomach and small bowel. The X-rays can be used to detect ulcers and other problems of the intestinal tract. The test is not painful.

In **urinalysis,** a small amount of urine is collected and tested for one to six factors that may reflect disease. An excess amount of sugar is found in the urine of diabetics.

To do a **urine check,** a strip of paper or a tablet is placed in a sample of urine to see whether a diabetic has taken enough insulin that day to regulate the sugar in his or her body.

Glossary

Achondroplastic dwarfism: *An inherited form of dwarfism or arrested growth. It results in overall smallness and especially short upper arms and thighs.*

Anemia: *A condition in which there is an abnormal reduction in the number of red blood cells present in the blood.*

Anoxia: *A complete lack of oxygen.*

Antibiotic: *A substance prescribed by a physician or dentist to kill or slow the growth of certain bacteria. Usually taken by mouth, antibiotics should always be taken for the prescribed length of time. There are no antibiotics that affect viruses.*

Antibodies: *Particles produced by the body to surround and destroy undesirable substances that enter the body, such as bacteria, viruses, molds, and pollen (which causes hayfever and other allergic reactions).*

Anticonvulsant: *A medicine used to control seizures. The amount to administer must be calculated on the patient's body weight.*

Benign: *Refers to a tumor or growth that can destroy tissue by pressing on it or by filling a body space required by another organ.*

Bladder: *The sac that holds the urine until urination can take place.*

Carbohydrate: *A food that provides energy. Normally obtained from sugar and cereals.*

Carbon dioxide: *The gas that is produced in body tissues as a waste product. It is removed from tissues by the blood. The blood then carries it to the lungs for exhalation.*

Central nervous system (CNS): *The brain and spinal cord.*

Cerebellum: *The small area of the brain at the base of the skull in the back of the head. It coordinates muscle movement, and is involved with balance.*

Chromosomes: *The parts of the cell that direct tissue development. The genes are carried on the chromosomes.*

Congenital: *Refers to a disease or condition that is present at birth, and that is not necessarily caused by inheritance.*

Constipation: *Difficult, incomplete, or infrequent bowel movements.*

Cranial nerves: *Twelve nerves that connect the brain with the muscles and sense organs of the face, neck, eyes, ears, nose, and mouth.*

Cyanosis: A condition in which a lack of oxygen in the blood causes the blood to be darker and the skin to look bluish.

Decongestant: A medicine used to dry up excess mucous caused by an upper respiratory infection.

Degenerative neurological disease: A condition that progressively destroys parts of the nervous system. This means that the symptoms of the condition become worse as time passes.

Diabetic coma: A situation in which a diabetic does not have sufficient insulin and becomes drowsy, then unconscious.

Dialysis: A procedure in which a machine is used to clear wastes from the blood. Dialysis is necessary when the kidneys are not functioning properly.

Diarrhea: Excessive bowel movements of loose, watery stool.

Eczema: A dry, scaling condition of the skin, usually the result of allergy.

Edema: Swelling of the body caused by excess fluid in the tissues.

Encopresis: A condition in which children continue to soil their pants after toilet-training. Most children with this problem can be helped by physicians and psychologists.

Enuresis: A condition in which there is uncontrolled urination. In diurnal enuresis, wetting occurs during the day; in nocturnal enuresis, wetting occurs at night.

Etiology: The origin or cause of a disease.

Failure to thrive: A situation in which a combination of health and/or psychological reasons results in a child's inability to gain weight and grow.

Familial disease: Refers to an inherited disease or condition that runs in families.

Familial dwarfism: An inherited form of dwarfism or arrested growth that results in overall smallness.

Fat: A food that supplies needed material both for body building and for energy.

Febrile seizure: A seizure caused by a rapidly rising fever. Febrile seizures are brief, and do not necessarily indicate that a child has epilepsy.

Focal seizure: A type of seizure in which there is jerking in a single limb or one side of the body.

Functional murmur: *See heart murmur.*

Genes: *The parts of the chromosome that direct the way in which body tissue develops. For example, genes direct the shape of the nose and the color of the hair.*

Heart murmur: *A sound made by the action of the heart when the valves between the heart chambers do not close completely.* ***Functional heart murmurs*** *are not harmful in any manner.* ***Organic heart murmurs*** *indicate serious problems.*

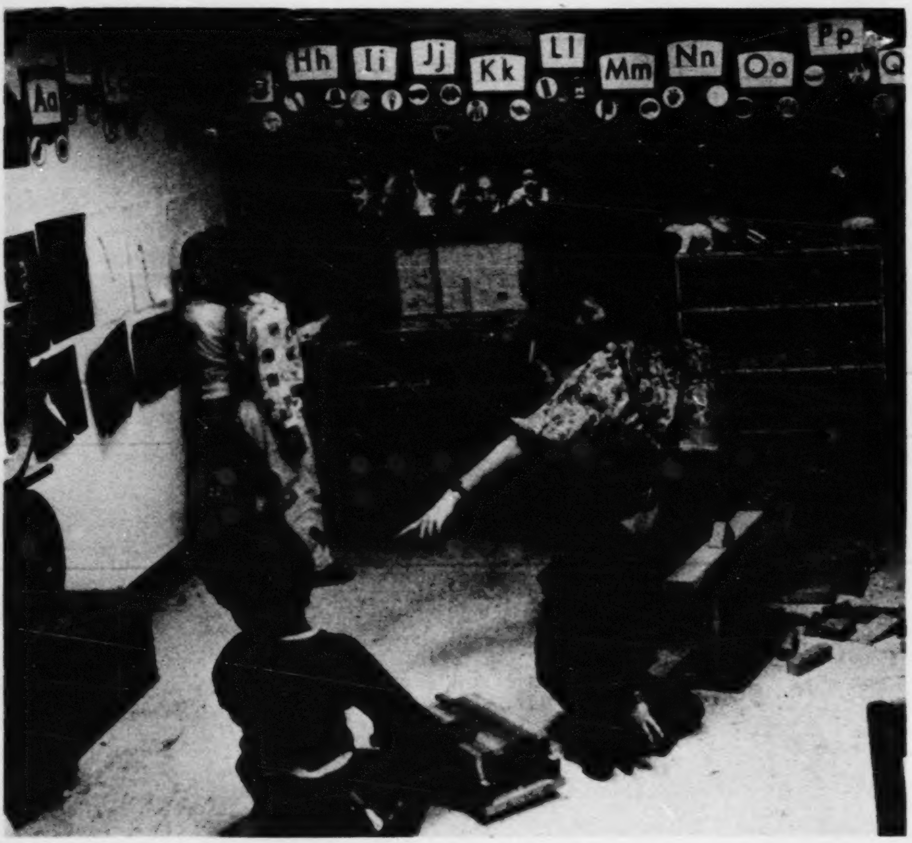
Hemophilia: *An inherited condition affecting males, in which the blood plasma contains an insufficient quantity of the factor needed to clot blood.*

Hereditary: *Refers to a disease or condition that is passed from parents to child.*

Hydrocephalus: *A condition in which the head is enlarged and the brain has excess fluid in the four ventricles (cavities) in the middle of the brain.*

Hypoxia: *A deficiency in the amount of oxygen reaching bodily tissues.*

Insulin: *The hormone required by the body for proper utilization of carbohydrates. Diabetics, who lack insulin, can be given insulin by injection.*



Insulin shock: *A situation in which a diabetic receives too much insulin and then uses up all available carbohydrates. Insulin shock may be associated with seizures.*

Jaundice: *A yellowish tinge or color of the skin, usually caused by problems in the liver.*

Leukemia: *A condition in which there is an abnormal increase in the number of white blood cells present in the blood. Also called cancer of the blood.*

Malignant: *Refers to a tumor or growth that destroys other tissue as it grows. Usually means that the tumor or growth is cancerous.*

Malnutrition: *A chronic lack of essential food stuffs, which results in a lack of physical growth.*

Megalencephaly: *A condition in which the head is enlarged and the brain is enlarged and abnormal. Usually associated with mental retardation.*

Metastatic: *Refers to the spread of tumor cells to other parts of the body.*

Microencephaly: *A condition in which the head and brain are significantly smaller than normal for age and sex.*

Motor cortex: *The surface of the brain that controls the muscles of the trunk, arms, and legs.*

Myoclonic seizure: *A type of seizure in which there are short, isolated jerks of the muscles.*

Myringotomy: *An incision made in the ear drum to drain fluid from an infected ear. In a* **myringotomy and tubes,** *a small "bobbin" of plastic is inserted in the incision to allow air to enter the middle ear and assist in the drainage of fluid.*

Neurocutaneous syndromes: *A group of conditions that combine skin and sensory or nervous difficulties.*

Organic murmur: *See heart murmur.*

Pigmentation: *Coloration of the skin and eyes.*

Pituitary dwarfism: *A form of dwarfism or arrested growth that is caused by failure of the pituitary gland. It results in overall smallness.*

Platelets: *Small particles in the blood that assist the blood in clotting.*

Post-ictal sleep: *Sleep that follows an epileptic seizure. It is natural and should be allowed.*

Primary tumor: *An original tumor (as opposed to a metastatic tumor).*

Protein: *A food that supplies the basic building materials required by the body. All children need adequate amounts of protein to assist in brain and body growth.*

Psychomotor seizure: *A type of seizure in which the child displays inappropriate behavior for the setting and automatic or involuntary movements and actions.*

Red blood cells (RBC): *The cells in the blood that carry oxygen to parts of the body where it is needed.*

Rubella: *German or three-day measles. Rubella is usually mild, but it can seriously harm a baby whose mother is infected early in her pregnancy.*

Sex linked condition: *A condition that is passed from parents to child through a sex chromosome. Mothers are carriers of the condition without having it themselves. Examples include muscular dystrophy and hemophilia.*

Shunt: *A tube that is surgically placed between the ventricles (cavities) of the brain and other organs such as the abdomen. Shunts are used to drain excess fluid and pressure from the brain.*

Status epilepticus: *A situation in which two major epileptic seizures occur, one right after the other. In such a case, immediate emergency room attention is required. Status epilepticus happens rarely.*

Stoma: *A surgical opening on the abdomen that allows drainage of either urine or stool into disposable bags.*

Strep sore throat: *A sore throat caused by streptococcal bacteria. It should be treated for a full ten days with an appropriate antibiotic.*

Symmetrical: *Having all parts evenly distributed.*

Syndrome: *A set of signs or symptoms that occur together repeatedly in a number of cases.*

Thyroid hormone: *Produced by the thyroid gland in the neck, this hormone is required during all phases of development, but particularly during infancy.*

Toxin: *Any substance that acts like a poison.*

Trachea: *The windpipe, which leads from the back of the throat to the lungs.*

Trauma: *A blow or injury.*

Upper respiratory infection (URI): *An infection of the ears, throat, and tonsils. Usually caused by a cold.*

Ureters: *The tubes that carry urine from the kidneys to the bladder.*

Urethra: *The tube that carries the urine from the bladder to the outside of the body.*

White blood cells (WBC): *The cells in the blood that assist the body in preventing infection.*

Chart of Normal Development: Infancy to Six Years of Age

The chart of normal development on the next few pages presents children's achievements from infancy to six years of age in five areas:

- **motor skills (gross and fine motor)**
- **cognitive skills**
- **self-help skills**
- **social skills**
- **communication skills (understanding language and speaking).**

In each skill area, the age at which each milestone is reached *on the average* is also presented. This information is useful if you have a child in your class who you suspect is seriously delayed in one or more skill areas.

However, it is important to remember that these milestones are only average. From the moment of birth, each child is a distinct individual, and develops in his or her unique manner. No two children have ever reached all the same developmental milestones at the exact same ages. The examples that follow show what we mean.

By nine months of age, Gi Lin had spent much of her time scooting around on her hands and tummy, making no effort to crawl. After about a week of pulling herself up on chairs and table legs, she let go and started to walk on her own. Gi Lin skipped the crawling stage entirely and scarcely said more than a few sounds until she was 15 months old. But she walked with ease and skill by 9½ months.

Marcus learned to crawl on all fours very early, and continued crawling until he was nearly 18 months old, when he started to walk. However, he said single words and used two-word phrases meaningfully before his first birthday. A talking, crawling baby is quite a sight!

Molly worried her parents by saying scarcely a word, although she managed to make her needs known with sounds and gestures. Shortly after her second birthday, Molly suddenly began talking in two- to four-word phrases and sentences. She was never again a quiet child.

All three children were healthy and normal. By the time they were three years old, there were no major differences among them in walking or talking. They had simply developed in their own ways and at their own rates. Some children seem to concentrate on one thing at a time — learning to crawl, to walk, or to talk. Other children develop across areas at a more even rate.

As you read the chart of normal development, remember that children don't read baby books. They don't know they're supposed to be able to point out Daddy when they are a year old, or copy a circle in their third year. And even if they could read the baby books, they probably wouldn't follow them! Age-related development milestones are obtained by averaging out what many children do at various ages. No child is "average" in all areas. Each child is a unique person.

One final word of caution. As children grow, their abilities are shaped by the opportunities they have for learning. For example, although many five-year-olds can repeat songs and rhymes, the child who has not heard songs and rhymes many times cannot be expected to repeat them. All areas of development and learning are influenced by the child's experiences as well as by the abilities they are born with.

Chart of Normal Development

	Motor Skills		**Communication Skills**	
	Gross Motor Skills	**Fine Motor Skills**	**Understanding Language**	**Spoken Language**
0-12 Months	Sits without support. Crawls. Pulls self to standing and stands unaided. Walks with aid. Rolls a ball in imitation of adult.	Reaches, grasps, puts object in mouth. Picks things up with thumb and one finger (pincer grasp). Transfers object from one hand to other hand. Drops and picks up toy.	Responds to speech by looking at speaker. Responds differently to aspects of speaker's voice (for example, friendly or unfriendly, male or female). Turns to source of sound. Responds with gesture to **hi, bye-bye,** and **up,** when these words are accompanied by appropriate gesture. Stops ongoing action when told **no** (when negative is accompanied by appropriate gesture and tone).	Makes crying and non-crying sounds. Repeats some vowel and consonant sounds (babbles) when alone or when spoken to. Interacts with others by vocalizing after adult. Communicates meaning through intonation. Attempts to imitate sounds.
12-24 Months	Walks alone. Walks backward. Picks up toys from floor without falling. Pulls toy, pushes toy. Seats self in child's chair. Walks up and down stairs (hand-held). Moves to music.	Builds tower of 3 small blocks. Puts 4 rings on stick. Places 5 pegs in pegboard. Turns pages 2 or 3 at a time. Scribbles. Turns knobs. Throws small ball. Paints with whole arm movement, shifts hands, makes strokes.	Responds correctly when asked **where,** (when question is accompanied by gesture). Understands prepositions **on, in,** and **under.** Follows request to bring familiar object from another room. Understands simple phrases with key words (for example, **Open the door,** or **Get the ball**). Follows a series of 2 simple but related directions.	Says first meaningful word. Uses single words plus a gesture to ask for objects. Says successive single words to describe an event. Refers to self by name. Uses **my** or **mine** to indicate possession. Has vocabulary of about 50 words for important people, common objects, and the existence, nonexistence, and recurrence of objects and events (for example, **more** and **all gone**).

Cognitive Skills		Self-Help Skills	Social Skills
Follows moving object with eyes. Recognizes differences among people. Responds to strangers by crying or staring. Responds to and imitates facial expressions of others. Responds to very simple directions (for example, raises arms when someone says, **Come,** and turns head when asked, **Where is Daddy?**).	Imitates gestures and actions (for example, shakes head no, plays peek-a-boo, waves bye-bye). Puts small objects in and out of container with intention.	Feeds self cracker. Holds cup with two hands. Drinks with assistance. Holds out arms and legs while being dressed.	Smiles spontaneously. Responds differently to strangers than to familiar people. Pays attention to own name. Responds to **no.** Copies simple actions of others.
Imitates actions and words of adults. Responds to words or commands with appropriate action (for example: **Stop that. Get down**). Is able to match two similar objects. Looks at storybook pictures with an adult, naming or pointing to familiar objects on request (for example:**What is that? Point to the baby**).	Recognizes difference between **you** and **me.** Has very limited attention span. Accomplishes primary learning through own exploration.	Uses spoon, spilling little. Drinks from cup, one hand, unassisted. Chews food. Removes shoes, socks, pants, sweater. Unzips large zipper. Indicates toilet needs.	Recognizes self in mirror or picture. Refers to self by name. Plays by self, initiates own play. Imitates adult behaviors in play. Helps put things away.

Chart of Normal Development

	Motor Skills Gross Motor Skills	Fine Motor Skills	**Communication Skills** Understanding Language	Spoken Language
24-36 Months	Runs forward well. Jumps in place, two feet together. Stands on one foot, with aid. Walks on tiptoe. Kicks ball forward.	Strings 4 large beads. Turns pages singly. Snips with scissors. Holds crayon with thumb and fingers, not fist. Uses one hand consistently in most activities. Imitates circular, vertical, horizontal strokes. Paints with some wrist action. Makes dots, lines, circular strokes. Rolls, pounds, squeezes, and pulls clay.	Points to pictures of common objects when they are named. Can identify objects when told their use. Understands question forms **what** and **where.** Understands negatives **no, not, can't,** and **don't.** Enjoys listening to simple storybooks and requests them again.	Joins vocabulary words together in two-word phrases. Gives first and last name. Asks **what** and **where** questions. Makes negative statements (for example, **Can't open it**). Shows frustration at not being understood.
36-48 Months	Runs around obstacles. Walks on a line. Balances on one foot for 5 to 10 seconds. Hops on one foot. Pushes, pulls, steers wheeled toys. Rides (that is, steers and pedals) tricycle. Uses slide without assistance. Jumps over 15 cm. (6") high object, landing on both feet together. Throws ball overhead. Catches ball bounced to him or her.	Builds tower of 9 small blocks. Drives nails and pegs. Copies circle. Imitates cross. Manipulates clay materials (for example, rolls balls, snakes, cookies).	Begins to understand sentences involving time concepts (for example, **We are going to the zoo tomorrow**). Understands size comparatives such as **big** and **bigger.** Understands relationships expressed by **if...then** or **because** sentences. Carries out a series of 2 to 4 related directions. Understands when told, **Let's pretend.**	Talks in sentences of three or more words, which take the form agent-action-object (**I see the ball**) or agent-action-location (**Daddy sit on chair**). Tells about past experiences. Uses "s" on nouns to indicate plurals. Uses "ed" on verbs to indicate past tense. Refers to self using pronouns **I** or **me.** Repeats at least one nursery rhyme and can sing a song. Speech is understandable to strangers, but there are still some sound errors.

Cognitive Skills		Self-Help Skills	Social Skills
Responds to simple directions (for example: **Give me the ball and the block. Get your shoes and socks**). Selects and looks at picture books, names pictured objects, and identifies several objects within one picture. Matches and uses associated objects meaningfully (for example, given cup, saucer, and bead, puts cup and saucer together). Stacks rings on peg in order of size. Recognizes self in mirror, saying, **baby**, or own name.	Can talk briefly about what he or she is doing. Imitates adult actions (for example, housekeeping play). Has limited attention span. Learning is through exploration and adult direction (as in reading of picture stories). Is beginning to understand functional concepts of familiar objects (for example, that a spoon is used for eating) and part/whole concepts (for example, parts of the body).	Uses spoon, little spilling. Gets drink from fountain or faucet unassisted. Opens door by turning handle. Takes off coat. Puts on coat with assistance. Washes and dries hands with assistance.	Plays near other children. Watches other children, joins briefly in their play. Defends own possessions. Begins to play house. Symbolically uses objects, self in play. Participates in simple group activity (for example, sings, claps, dances). Knows gender identity.
Recognizes and matches six colors. Intentionally stacks blocks or rings in order of size. Draws somewhat recognizable picture that is meaningful to child, if not to adult. Names and briefly explains picture. Asks questions for information (**why** and **how** questions requiring simple answers). Knows own age. Knows own last name.	Has short attention span. Learns through observing and imitating adults, and by adult instruction and explanation. Is very easily distracted. Has increased understanding of concepts of the functions and groupings of objects (for example, can put doll house furniture in correct rooms), and part/whole (for example, can identify pictures of hand and foot as parts of body). Begins to be aware of past and present (for example: **Yesterday we went to the park. Today we go to the library**).	Pours well from small pitcher. Spreads soft butter with knife. Buttons and unbuttons large buttons. Washes hands unassisted. Blows nose when reminded. Uses toilet independently.	Joins in play with other children. Begins to interact. Shares toys. Takes turns with assistance. Begins dramatic play, acting out whole scenes (for example, traveling, playing house, pretending to be animals).

Chart of Normal Development

	Motor Skills		Communication Skills	
	Gross Motor Skills	Fine Motor Skills	Understanding Language	Spoken Language
48-60 Months	Walks backward toe-heel. Jumps forward 10 times, without falling. Walks up and down stairs alone, alternating feet. Turns somersault.	Cuts on line continuously. Copies cross. Copies square. Prints a few capital letters.	Follows three unrelated commands in proper order. Understands comparatives like pretty, prettier, and prettiest. Listens to long stories but often misinterprets the facts. Incorporates verbal directions into play activities. Understands sequencing of events when told them (for example, **First we have to go to the store, then we can make the cake, and tomorrow we will eat it**).	Asks **when, how,** and **why** questions. Uses modals like **can, will, shall, should,** and **might.** Joins sentences together (for example, **I like chocolate chip cookies and milk**). Talks about causality by using **because** and **so.** Tells the content of a story but may confuse facts.
60-72 Months	Runs lightly on toes. Walks on balance beam. Can cover 2 meters (6′6″) hopping. Skips on alternate feet. Jumps rope. Skates.	Cuts out simple shapes. Copies triangle. Traces diamond. Copies first name. Prints numerals 1 to 5. Colors within lines. Has adult grasp of pencil. Has handedness well established (that is, child is left- or right-handed). Pastes and glues appropriately.	Demonstrates pre-academic skills.	There are few obvious differences between child's grammar and adult's grammar. Still needs to learn such things as subject-verb agreement, and some irregular past tense verbs. Can take appropriate turns in a conversation. Gives and receives information. Communicates well with family, friends, or strangers.

Cognitive Skills		Self-Help Skills	Social Skills
Plays with words (creates own rhyming words; says or makes up words having similar sounds). Points to and names 4 to 6 colors. Matches pictures of familiar objects (for example, shoe, sock, foot; apple, orange, banana). Draws a person with 2 to 6 recognizable parts, such as head, arms, legs. Can name or match drawn parts to own body. Draws, names, and describes recognizable picture. Rote counts to 5, imitating adults.	Knows own street and town. Has more extended attention span. Learns through observing and listening to adults as well as through exploration. Is easily distracted. Has increased understanding of concepts of function, time, part/whole relationships. Function or use of objects may be stated in addition to names of objects Time concepts are expanding. The child can talk about yesterday or last week (a long time ago), about today, and about what will happen tomorrow.	Cuts easy foods with a knife (for example, hamburger patty, tomato slice). Laces shoes.	Plays and interacts with other children. Dramatic play is closer to reality, with attention paid to detail, time, and space. Plays dress-up. Shows interest in exploring sex differences.
Retells story from picture book with reasonable accuracy. Names some letters and numerals. Rote counts to 10. Sorts objects by single characteristics (for example, by color, shape, or size if the difference is obvious). Is beginning to use accurately time concepts of **tomorrow** and **yesterday.** Uses classroom tools (such as scissors and paints) meaningfully and purposefully.	Begins to relate clock time to daily schedule. Attention span increases noticeably. Learns through adult instruction. When interested, can ignore distractions. Concepts of function increase as well as understanding of why things happen. Time concepts are expanding into an understanding of the future in terms of major events (for example, **Christmas will come after two weekends**).	Dresses self completely. Ties bow. Brushes teeth unassisted. Crosses street safely.	Chooses own friend(s). Plays simple table games. Plays competitive games. Engages with other children in cooperative play involving group decisions, role assignments, fair play.

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